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BACKGROUND MATERIALS ON HEALTH CARE COVERAGE AND EXPENSES OF THE MEDICARE POPULATION

Including H.R. 1280/H.R. 1281, the Medicare Catastrophic Protection Acts of 1987

AS APPROVED BY THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS

MAY 5, 1987

Prepared for the use of the Committee on Ways and Means by its staff

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SECTION I. BACKGROUND ON HEALTH CARE FOR THE ELDERLY

A. Demographics of the Elderly

The population of the United States has grown increasingly older during the twentieth century, and this trend is expected to continue into the next century. The elderly population has grown much more rapidly in this century than has the remainder of the population. As table 1 shows, from 1900 to 1950, the total population doubled in size while the population aged 65 and over increased by four times; from 1950 to 1980, when the total population increased by 50 percent, the aged population doubled in size, to 25.5 million. Between 1980 and the year 2020, the total population is projected to increase by slightly more than 30 percent, while the elderly population is projected to more than double again. By 2020, the projected elderly population will be 51.4 million, 17.3 percent of the total population.

TABLE 1.—SIZE OF THE ELDERLY POPULATION, 1900 TO 2020

[In thousands]

Year	Total U.S. population	Age 65 and over	
		Number	Percent
1900	76,303	3,084	4.0
1950	150,697	12,270	8.1
1980	226,505	25,544	11.3
2000	267,955	34,921	13.0
2020	296,597	51,422	17.3

Source: U.S. Department of Commerce. Bureau of the Census. Decennial Censuses of Population 1900–1980 and Projections of the Population of the United States by Age, Sex, and Race: 1983 to 2080 (Advance Report). Current Population Reports, Series P–25. No. 952. May 1984. Projections are middle series.

B. Health Status of the Elderly

Despite the trend toward generally improved health status of the elderly, their needs for health care remain substantial. First, greater life expectancy merely postpones the inevitable need for terminal illness care. (About two-thirds of the deaths in the United States are of the elderly.) A recent study found that the 6 percent of Medicare beneficiaries who died in 1978 accounted for 28 percent of Medicare expenditures.[1] Second, many of the elderly have one or

[1] J. Lubitz and R. Prihoda, "The Use and Costs of Medicare Services in the Last Two Years of Life," Health Care Financing Review, Volume 5, 1984, pp. 117–131.

more chronic conditions, many of which give rise to the need for continuing health care. Table 2 shows the incidence of several common chronic conditions among the elderly. Nearly half report having arthritis, 40 percent report high blood pressure, and nearly one-third report heart disease. The incidence of many chronic conditions is directly related to age and inversely related to family income.

TABLE 2.—NUMBER OF SELECTED CHRONIC CONDITIONS PER 1,000 ELDERLY PERSONS, BY AGE AND FAMILY INCOME, 1984

Type of chronic condition	All elderly	Age		Family income [1]		
		65–74	75 and over	Less than $10,000	$10,000 to $19,999	$20,000 to $34,999
Arthritis	490	463	533	594	406	522
Cataracts	150	100	230	206	126	94
Hearing impairment	311	258	396	346	317	266
Deformity or orthopedic impairment	173	164	186	236	146	148
Hernia of abdominal cavity	87	86	87	94	81	92
Diabetes	103	105	100	119	114	77
Heart disease	320	305	345	368	314	358
High blood pressure (hypertension)	406	397	421	479	419	385
Emphysema	42	40	45	50	44	57

[1] Too few elderly at incomes of $35,000 and above were surveyed to provide reliable estimates for most conditions.

Source: National Center for Health Statistics, Current Estimates from the National Health Interview Survey, United States, 1984, Vital and Health Statistics, Series 10, No. 156, pp. 81, 82, 87–90. Data are based on household interviews of the civilian, noninstitutionalized population.

C. Health Care Expenditures for the Elderly

Expenditures for personal health care services for the elderly nearly tripled between 1977 and 1984, rising from $43 billion to an estimated $120 billion (see table 3). Per capita spending rose an average of 13 percent annually during those years, from $1,785 to $4,202 (see table 4).

Government programs (Federal and State) account for two-thirds ($2,823 per capita) of estimated 1984 spending for the aged (see table 5). The most significant of these programs is Medicare which pays for nearly half ($2,051 per capita) of the aged's health bill. Medicaid funds about 13 percent ($536 per capita) of the aged's expenditures. Other Government health programs are the source of roughly 6 percent ($236 per capita) of personal health care expenditures for people 65 years of age and over.

TABLE 3.—PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977 AND 1984

[In millions of dollars]

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total	43,425	18,906	7,782	10,696	6,041
Private	15,669	2,319	3,323	5,424	4,603
Consumer	15,499	2,263	3,320	5,352	4,564
Out-of-pocket	12,706	927	2,147	5,264	4,368
Insurance	2,793	1,336	1,173	88	195
Other private	170	56	3	72	39
Government	27,756	16,587	4,458	5,272	1,438
Medicare	19,171	14,087	4,158	348	578
Medicaid	6,049	733	232	4,453	631
Other government	2,536	1,767	68	470	230
Exhibit: Population (in millions)	24.3				
1984					
Total	119,872	54,200	24,770	25,105	15,798
Private	39,341	6,160	9,827	13,038	10,316
Consumer	38,875	5,964	9,818	12,856	10,237
Out-of-pocket	30,198	1,694	6,468	12,569	9,467
Insurance	8,677	4,270	3,350	287	770
Other private	466	196	9	182	79
Government	80,531	48,040	14,943	12,067	5,482
Medicare	58,519	40,524	14,314	539	3,142
Medicaid	15,288	2,595	467	10,418	1,808
Other government	6,724	4,920	162	1,110	532
Exhibit: Population (in millions)	28.5				

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration, as reported in Waldo, Daniel R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review, Fall 1984 No. 1, p. 1.

TABLE 4.—PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE, 1977 AND 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing	Other care
1977					
Total	$1,785	$777	$230	$440	$248
Private	644	95	137	223	189
Consumer	637	93	136	220	188
Out-of-pocket	522	38	88	216	180
Insurance	115	55	48	4	8
Other private	7	2	(1)	3	2
Government	1,141	682	183	217	59
Medicare	788	579	171	14	24
Medicaid	249	30	10	183	26
Other government	104	73	3	19	9
1984					
Total	4,202	1,900	868	880	554
Private	1,379	216	344	457	362
Consumer	1,363	209	344	451	359
Out-of-pocket	1,059	59	227	441	332
Insurance	304	150	117	10	27
Other private	16	7	(1)	6	3
Government	2,823	1,684	524	423	192
Medicare	2,051	1,420	502	19	110
Medicaid	536	91	16	365	63
Other government	236	172	6	39	19

[1] Less than $.50.

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration as reported in Waldo, Daniel, R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review. Fall 1984 No. 1, p. 1.

TABLE 5.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: 1977 AND 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1977					
Total per capita	100.0	100.0	100.0	100.0	100.0
Private	36.1	12.3	42.7	50.7	76.2
Consumer	35.7	12.0	42.7	50.0	75.5
Out-of-pocket	29.3	4.9	27.6	49.2	72.3
Insurance	6.4	7.1	15.1	0.8	3.2
Other private	0.4	0.3	.0	0.7	0.6
Government	63.9	87.7	57.3	49.3	23.8
Medicare	44.1	74.5	53.4	3.3	9.6
Medicaid	13.9	3.9	3.0	41.6	10.4
Other government	5.8	9.3	0.9	4.4	3.8
1984					
Total per capita	100.0	100.0	100.0	100.0	100.0
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9
Insurance	7.2	7.9	13.5	1.1	4.9
Other private	0.4	0.4	.0	0.7	0.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicaid	12.8	4.8	1.9	41.5	11.4
Other government	5.6	9.1	0.7	4.4	3.4

Source: Office of Financial and Actuarial Analysis, Health Care Financing Administration, as reported in Waldo, Daniel, R., and Helen C. Lazenby. "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977–1984." Health Care Financing Review. Fall 1981 No. 1, p. 1.

Consumers are responsible for the remaining one-third ($1,379 per capita) of spending for the aged. One-quarter ($1,059 per capita) of the total health bill for the aged was paid by direct patient payments, also termed out-of-pocket expenses. Out-of-pocket payments by the elderly represent the difference between total health expenditures by the aged and known third-party (public expenditures and private insurance) payments. These out-of-pocket payments include Medicare copayments (less any benefits paid for by so-called "medigap" policies), collected reasonable charge reductions, net private health insurance copayments, and the purchase of care not covered by any third party. It is important to note that direct out-of-pocket payments to providers are not the only expenditures by the aged for health care. The aged also pay supplementary medical insurance (SMI or part B) and private health insurance premiums which are not defined as out-of-pocket expenditures. Private health insurance, including medigap policies, covers an additional estimated 7 percent ($304 per capita) of personal health care expenditures for the elderly.

Table 6 illustrates out-of-pocket spending for medical care by the elderly as a percent of their income.

TABLE 6.—ANNUAL OUT-OF-POCKET SPENDING BY ELDERLY FOR MEDICAL CARE AS A PERCENT OF INCOME, 1986

Income level	Percent of income spent on medical care
Under $5,000	18
$5,000–$9,999	12
$10,000–$14,999	9
$15,000–$19,999	7
$20,000 and above	4

Source: National Medical Care Utilization and Expenditure Survey, National Center for Health Statistics, 1980 data adjusted to 1986 for work in progress; received in telephone conversation with Judith Feder, Ph.D., Co-Director, Center for Health Policy Studies, Georgetown University Department of Community and Family Medicine.

SECTION II. MEDICARE

Medicare, authorized under title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It consists of two parts: the hospital insurance (part A) program and the supplementary medical insurance (part B) program.

A. Eligibility

Most Americans age 65 or older are automatically entitled to protection under part A. Persons age 65 or older who are not "fully insured" (i.e., not eligible for monthly Social Security or railroad retirement cash benefits) may obtain coverage, providing they pay the full actuarial cost of such coverage. The monthly premium, as of January 1, 1987, is $226. Also eligible, after a 2-year waiting period, are people under age 65 who are receiving monthly Social Security benefits on the basis of disability and disabled railroad retirement system annuitants. (Dependents of the disabled are not eligible.) Most people who need a kidney transplant or renal dialysis because of chronic kidney disease are, under certain circumstances, entitled to benefits under part A regardless of age.

Most individuals establish entitlement to part A on the basis of work in employment covered by either the Social Security or railroad retirement systems. Certain employment is excluded from Social Security (including part A Hospital Insurance) taxation.

The Tax Equity and Fiscal Responsibility Act of 1982 extended the hospital insurance tax to Federal employment effective with respect to wages paid on or after January 1, 1983. For calendar year 1987, the tax will be 1.45 percent of wages up to $43,800. Beginning January 1, 1983, Federal employment is used to determine eligibility for protection under Medicare part A. A transitional provision allows individuals employed by the Federal Government both before and during January 1, 1983, to have their prior Federal employment considered as employment for purposes of providing Medicare coverage. Newly hired employees of State and local governments hired after March 31, 1986, are liable for the Hospital Insurance tax.

Part B of Medicare is voluntary. All persons age 65 or older (whether "insured" or not) may elect to enroll in the supplementary medical insurance program by paying the monthly premium. Persons eligible for part A by virtue of disability or chronic kidney disease may also elect to enroll in part B. The premium, as of January 1, 1987, is $17.90.

B. Number of Beneficiaries

In fiscal year 1987, approximately 28.4 million aged and 3.0 million disabled will have protection under part A. Of those, it is esti-

mated that 6.5 million aged and 0.7 million disabled will actually receive reimbursed services. In fiscal year 1987, 28.3 million aged and 2.7 million disabled will be enrolled in part B. About 21.9 million of the aged and 2.0 million of the disabled will receive part B reimbursed services.

TABLE 1.—NUMBER OF AGED AND DISABLED ELIGIBLE ENROLLEES AND BENEFICIARIES AND AVERAGE AND TOTAL MEDICARE BENEFIT PAYMENTS

[Persons in thousands]

	1980 (actual)	1985 (actual)	1987 [1] (estimate)	1988 [1] (estimate)	Projected average annual growth 1980–88
Part A:					
Persons with hospital insurance protection (monthly average):					
Aged	24,572	27,203	28,449	29,032	2.3
Disabled	2,959	2,906	2,951	2,966	—.1
Beneficiaries receiving reimbursed services:					
Aged	5,943	6,430	6,540	6,710	2.2
Disabled	737	745	745	750	.2
Average annual benefit per person enrolled: [2]					
Aged	$853	$1,560	$1,477	$1,580	10.5
Disabled	$951	$1,861	$1,778	$1,900	12.2
Total benefit payments per beneficiary reimbursed:					
Aged	$3,527	$6,599	$6,426	$6,838	10.8
Disabled	$3,817	$7,260	$7,043	$7,515	11.1
Part B:					
Persons enrolled (average):					
Aged	24,410	27,110	28,328	28,886	2.2
Disabled	2,703	2,671	2,713	2,731	1.1
Beneficiaries receiving reimbursed services:					
Aged	15,525	19,350	21,905	22,582	4.9
Disabled	1,737	1,877	1,998	2,011	3.5
Average annual benefit per person enrolled: [2]					
Aged	$349	$686	$904	$1,015	15.3
Disabled	$604	$1,094	$1,227	$1,363	11.3
Total benefit payments per beneficiary reimbursed:					
Aged	$548	$961	$1,169	$1,298	12.3
Disabled	$940	$1,714	$1,666	$1,851	9.1

[1] Represents current law. Includes Administration regulations but not legislative proposals.
[2] Does not include administrative cost.

Source: Health Care Financing Administration.

C. Benefits

The Medicare program was designed to meet the acute health care needs of the elderly. The acute care focus is evidenced in the benefit design of the Hospital Insurance (part A) program and Supplementary Medical Insurance (part B) program.

Fairly extensive coverage is provided for short-term hospital stays under part A. Coverage for long-term hospital stays is less adequate. These long stays are subject to significant coinsurance charges; further, a beneficiary may potentially exhaust all benefits (see table 2). However, a very small percentage of beneficiaries (0.7 percent in 1983) exceed 60 days of hospital care in a spell of illness. (A spell of illness is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been an inpatient in a hospital or skilled nursing facility for 60 days). An even smaller percentage (0.2 percent in 1985) exhaust their lifetime reserve days.

Beneficiaries enrolled in part B pay a monthly premium ($17.90 a month in 1987). They are also liable for certain charges in connection with their use of physicians and other services covered under the program (see table 2). All beneficiaries are liable for the $75 deductible and 20 percent coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., agree to accept Medicare's determination of the reasonable charge amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge.

TABLE 2.—SUMMARY OF MEDICARE BENEFITS AND ASSOCIATED BENEFICIARY COST-SHARING CHARGES

Coverage	Beneficiary payments
Part A	
Inpatient Hospital Services [1]:	
Per spell of illness:	
First 60 days	$520 deductible.[2]
61st–90th day	$130 daily coinsurance.[2]
60 lifetime reserve days	$260 daily coinsurance.[2]
Post-hospital SNF services:	
First 20 days	None.
21st–100th day	$65 daily coinsurance.[2]
Home health services	None.
Hospice services	Subject to durational limits and copayments for outpatient drugs and respite care.
Part B	
Physicians' services and other medical services[1].	1) $75 deductible. 2) 20% coinsurance. 3) Amounts in excess of reasonable charges on unassigned claims (balance billing).

[1] Special limits apply with respect to inpatient services in a psychiatric hospital under part A and outpatient psychiatric physician's services under part B. Limits are also applied to annual program payments for physical therapy services provided by an independent practitioner.

[2] Part A deductible and coinsurance amounts are increased annually; coinsurance amounts are calculated as specified percentages of the deductible.

Table 3 shows the benefit payments under both part A and part B for fiscal years 1978, 1983, and 1988. Table 4 illustrates the deductible, coinsurance, and premium amounts for both part A and part B services from the inception of Medicare.

TABLE 3.—BENEFIT PAYMENTS BY SERVICE UNDER PART A AND PART B, FISCAL YEARS 1978, 1983, AND 1988

[Dollars in millions]

	1978 payments (actual)		1983 payments (actual)		1988 payments [1] (estimate)		Projected average annual growth (1978–88)
	Amount	Percent	Amount	Percent	Amount	Percent	
Part A							
For inpatient hospital services	$16,685	68.8	$36,079	64.9	$47,565	56.3	11.8
For skilled nursing facility services	353	1.5	507	0.9	695	0.8	6.5
For home health services	361	1.5	1,576	2.7	3,171	3.7	25.0
For hospice services	0	0	0	0	90	0.1	.....
Total benefit payments	17,399	71.8	38,102	68.5	51,521	60.9	12.2
Part B							
For physician services	954	20.4	12,769	23.0	23,836	28.2	17.0
For radiology and pathology services	373	1.5	730	1.3	.....	.....	10.8
For outpatient services	1,105	4.6	3,346	6.0	7,364	8.7	20.6
For other medical and health services	420	1.7	642	1.2	1,841	2.2	17.9
Total benefit payments	6,852	28.2	17,487	31.5	33,041	39.1	17.1
Total	24,251	100.0	55,589	100.0	84,562	100.0	13.7

[1] Represents current law. Includes Administration regulations but not legislative proposals. Also includes funding for peer review organizations.

Source: Health Care Financing Administration.

TABLE 4.—HISTORICAL AND PROJECTED AMOUNTS OF PART A (HOSPITAL INSURANCE) AND PART B (SMI) DEDUCTIBLE, COINSURANCE, AND PREMIUMS [1]

For benefit periods beginning in	Inpatient hospital [2]			Skilled nursing facility 21st thru 100th day coinsurance per day [5]	HI monthly premium [6]		SMI deductible	SMI premium	
	First 60 days deductible	61st thru 90th day coinsurance per day [3]	60 lifetime reserve days (nonrenewable) coinsurance per day [4]		Effective date	Amount		Effective date	Amount
1966	$40	$10	([7])	([7])	.....	.....	$50	7/66	$3.00
1967	40	10	([7])	$5.00	.....	.....	50	.....	3.00
1968	40	10	$20	5.00	.....	.....	50	4/68	4.00
1969	44	11	22	5.50	.....	.....	50	.....	4.00
1970	52	13	26	6.50	.....	.....	50	7/70	5.30
1971	60	15	30	7.50	.....	.....	50	7/71	5.60
1972	68	17	34	8.50	.....	.....	50	7/72	5.80
1973	72	18	36	9.00	7/73	$33	60	[8] 9/73	6.30
1974	84	21	42	10.50	7/74	36	60	7/74	6.70
1975	92	23	46	11.50	7/75	40	60	.....	6.70
1976	104	26	52	13.00	7/76	45	60	7/76	7.20
1977	124	31	62	15.50	7/77	54	60	7/77	7.70
1978	144	36	72	18.00	7/78	63	60	7/78	8.20
1979	160	40	80	20.00	7/79	69	60	7/79	8.70
1980	180	45	90	22.50	7/80	78	60	7/80	9.60
1981	204	51	102	25.50	7/81	89	60	7/81	11.00
1982	260	65	130	32.50	7/82	113	75	7/82	12.20
1983	304	76	152	38.00	.....	113	75	.....	12.20
1984	356	89	178	44.50	1/84	155	75	1/84	14.60

1985	400	100	200	50.00	1/85	174	75	1/85	15.50
1986	492	123	246	61.50	1/86	214	75	1/86	15.50
1987	520	130	260	65.00	1/87	226	75	1/87	17.90
1988 [9]	536	134	268	67.00	1/88	233	75	1/88	22.80
1989 [9]	552	138	276	69.00	1/89	240	75	1/89	23.60
1990 [9]	568	142	284	71.00	1/90	247	75	1/90	24.40
1991 [9]	584	146	292	73.00	1/91	254	75	1/91	25.30
1992 [9]	600	150	300	75.00	1/92	261	75	1/92	26.10

[1] For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services were furnished. For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.
[2] For care in psychiatric hospital—190 day lifetime limit.
[3] Always equal to ¼ of inpatient hospital deductible.
[4] Always equal to ½ of inpatient hospital deductible.
[5] Always equal to ⅛ of inpatient hospital deductible.
[6] Not applicable prior to July 1973. Applies to individuals who are not fully insured.
[7] Not covered.
[8] For August 1973 the premium was $6.10.
[9] Administration projections under fiscal year 1988 budget assumptions.

Note: In addition to the deductible and coinsurance amounts shown in the table, the first 3 pints of blood are not reimbursed by Medicare. Currently there is no deductible or coinsurance on home health benefits. From January 1973 to June 30, 1982, there was a $60 annual deductible and prior to July 1, 1981, benefits were limited to 100 visits per benefit period under part A and 100 visits per calendar year under part B. Special limits apply to certain benefits: (1) Outpatient physician services for mental illness: 50 percent of approved charges; up to a maximum of $250 in benefits per year; (2) Physical therapy services furnished by physical therapists in independent practice: Maximum annual approved charges July 1, 1973, through December 31, 1981, $80 per year; January 1, 1982 through December 31, 1982, $400 per year, and January 1, 1983 and thereafter, $500 per year.

Source: Health Care Financing Administration, Office of the Actuary.

1. Hospital services

Part A of Medicare will pay for all reasonable inpatient hospital care expenses for the first 60 days minus a deductible ($520 in calendar year 1987) in each benefit period. For days 61–90, a coinsurnace amount ($130 in calendar year 1987) is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60 day life-time reserve. A coinsurance amount ($260 in calendar year 1987) is also deducted for each reserve day.

The Social Security Amendments of 1983 (Public Law 98–21) altered the way in which Medicare pays hospitals. From the inception of the program, Medicare had paid hospitals on a "reasonable cost" basis. Effective October 1, 1983, Medicare began paying under a prospective payment system. Medicare payments for inpatient operating costs of hospitals are detemined in advance and made on a per discharge basis. A fixed amount per case is paid based upon the type of case or "diagnosis-related group" (DRG) into which the case is classified.

The payment system is not applied to capital-related costs nor to direct medical education costs. These expenses continue to be reimbursed on a reasonable cost basis. Capital costs may no longer be excluded from the system beginning October 1, 1987. Certain hospitals excluded from the system are: psychiatric, long-term care, children's, and rehabilitation hospitals. Excluded hospitals continue to be paid based on reasonable costs subject to certain rate of increase limitations.

Additional payments are made for extraordinarily costly cases, for the indirect costs of medical education, and for hospitals serving a disproportionate share of low income patients. An adjustment is made for the wage level in the area in which the hospital is located. In addition, there are certain other exceptions and adjustments including those for sole community providers, national and regional referral centers, and cancer treatment centers.

The payment system is being phased in over 4 years from payments based on an individual hospital's historical costs to payments based on the new prospective payments rates. In addition, the system is being phased in from payments representing nine regional payment levels to one national payment level for each DRG. There are separate payment levels for urban and rural areas.

Hospitals and other institutional providers receiving payment under Medicare part A submit bills on behalf of the beneficiary and agree to accept the program's payment as payment in full. In general, providers are permitted to charge beneficiaries only the deductible and coinsurance amounts authorized by law.

Table 5 includes data on Medicare per capita reimbursement for inpatient hospital services.

TABLE 5.—MEDICARE PART A AND PART B PER CAPITA REIMBURSEMENT FOR AGED AND DISABLED ENROLLEES, INPATIENT HOSPITAL SERVICES BY AGE, SEX, AND RACE, 1983

Age, sex, and race	Inpatient hospital
Aged:	
Total	$1,142
Age:	
65–69 years	824
70–74 years	1,057
75–79 years	1,300
80–84 years	1,525
85 years or over	1,644
Sex:	
Male	1,228
Female	1,085
Race:	
White	1,135
All others	1,252
Disabled:	
Total	1,271
Age:	
Under 35 years	1,013
35–44 years	1,064
45–54 years	1,256
55–59 years	1,326
60–64 years	1,435
Sex:	
Male	1,164
Female	1,457
Race:	
White	1,266
All others	1,307

[1] Excludes persons with end-stage renal diseases.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

2. Physician services

Medicare part B provides insurance coverage for physician services and for certain services provided by other noninstitutional providers including surgery, consultation, and home, office and institutional visits. Certain limitations apply for services rendered by dentists, podiatrists and chiropractors, and for the treatment of mental illness. To be entitled to benefits under Medicare part B, individuals eligible for hospital benefits under part A must enroll in part B and pay a monthly premium.

Payments are made for services covered under part B after an annual deductible requirement of $75 has been satisfied. Payment is set at 80 percent of the Medicare approved "reasonable" charge. Beneficiaries are responsible for the remaining 20 percent as coinsurance.

For physicians' services, the Medicare approved reasonable charge is limited to the lowest of the following amounts: (1) the physician's actual charge for the service; (2) the physician's customary charge for the service; or (3) the prevailing charge for the service as provided by physicians in a particular locality. Since 1973, annual increases in prevailing charge levels have been limited by the Medicare Economic Index (MEI). The index reflects year-to-year changes in general wage levels and physician practice costs. Customary and prevailing charge screens generally are updated every year. However, payments were temporarily frozen from July 1, 1984 to December 31, 1986.

In limited situations, the Secretary of Health and Human Services may make an adjustment in payment levels if he determines that application of the standard payment methodology results in a payment level that is not "inherently reasonable." Standards and procedures for application of the inherent reasonableness authority are specified by statute. Based on similar considerations, Congress has required a reduction in payment for cataract surgery and related anesthesia services effective July 1, 1987.

Medicare payment is made either on an "assigned" or "unassigned" basis. By accepting assignment, physicians agree to accept the Medicare approved charge as payment-in-full. Thus, if assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments. In contrast, if assignment is not accepted, beneficiaries may be liable for charges in excess of the Medicare approved charge.

Medicare's participating physician program was established in 1984 to provide beneficiaries with the opportunity to select a physician who has agreed to accept assignment on all services provided during a 12-month period. Nonparticipating physicians continue to be able to accept or refuse assignment on a claim-by-claim basis. A number of incentives are provided to encourage physicians to sign participation agreements. These include: higher prevailing charge screens, more rapid claims payment, and wide-spread distribution of participating directories.

To ensure that limitations on Medicare payments do not result in higher out-of-pocket costs for beneficiaries, the actual charges of nonparticipating physicians are limited during a 4-year period beginning on January 1, 1987. Under the maximum allowable actual charge (MAAC) limits, nonparticipating physicians with actual charges in excess of 115 percent of the prevailing charge are limited to a 1 percent a year increase in their actual charges. Nonparticipating physicians with lower actual charges may increase their charges at a more rapid rate.

Table 6 includes data on Medicare per capita reimbursement for physicians' services.

TABLE 6.—MEDICARE PART A AND PART B PER CAPITA REIMBURSEMENT FOR AGED AND DISABLED ENROLLEES, PHYSICIAN AND RELATED SERVICES BY AGE, SEX, AND RACE, 1983

Age, sex, and race	Physician and related services
Aged:	
Total	$460
Age:	
65–69 years	375
70–74 years	453
75–79 years	514
80–84 years	550
85 years or over	551
Sex:	
Male	493
Female	439
Race:	
White	466
All other	420
Disabled: [1]	
Total	490
Age:	
Under 35 years	329
35–44 years	392
45–54 years	496
55–59 years	531
60–64 years	563
Sex:	
Male	446
Female	563
Race:	
White	503
All other	434

[1] Excludes persons with end-stage renal disease.

Source: Health Care Financing Administration, Bureau of Data Management and Strategy.

3. Skilled nursing facility care

Part A of Medicare will pay for up to 100 days of skilled nursing facility care (following hospitalization) for persons in need of continued skilled nursing care and/or skilled rehabilitation services on a daily basis. After the first 20 days, there is a daily coinsurance amount deducted ($65 in calendar year 1987).

Medicare covers skilled nursing facility services only after the covered individual has been discharged and transferred from the hospital in which the individual was a patient for at least 3 consecutive days.

In general, skilled nursing facilities are reimbursed on the basis of reasonable costs subject to certain limits. Reimbursement limits for skilled nursing facilities have been established for inpatient general routine service costs. Limits are set at 112 percent of the averge labor-related and average non-labor related costs of each comparison group. For cost reporting periods beginning on or after July 1, 1984, separate limits are established for freestanding facilities in urban and rural areas at 112 percent of the mean operating costs of urban and rural freestanding facilities, respectively. Limits for urban or rural hospital-based facilities are set at the appropriate freestanding facility limit plus 50 percent of the difference between the freestanding facility limit and 112 percent of the mean operating costs of hospital-based facilities. Adjustments to take into account administrative costs for hospital based facilities are allowed as an add on.

Public Law 99-272 established a prospective payment rate system for certain SNFs that elect such payment for cost reporting periods beginning on or after October 1, 1986. SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year would have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate is to be separately calculated for urban and rural areas and the prospective per diem rate also is to reflect wage differences between urban and rural areas within each region. These rates cannot exceed the per diem cost limit that would otherwise be applicable to that facility and cannot exceed its cost limit adjusted for capital costs.

TABLE 7.—SKILLED NURSING FACILITY DATA

Fiscal year	Number of SNF facilities	Total covered days of care (thousands)	Total interim reimbursement (thousands)	Interim reimbursement per day
1977	4,461	9,757.7	$314,149	$32
1978	4,982	9,231.5	317,505	34
1979	5,055	8,643.7	329,498	38
1980	5,155	8,644.2	356,633	41
1981	5,295	8,581.2	390,408	45
1982	5,510	8,564.2	420,644	49
1983	5,760	9,100.3	458,854	50
1984	6,183	9,209.5	475,802	52
1985 [1]	6,725	8,070.4	457,400	57

[1] Data are considered preliminary.

Source: Health Care Financing Administration, Bureau of Data Management and Statistics. Derived from Medicare Statistical System (MSS), Current Utilization Series, Table 8, October 31, 1986.

4. Home health care

The hospital insurance (part A) and the supplementary medical insurance (part B) programs cover home health services without a deductible or coinsurance charge. There is no limitation on the

number of home health visits covered under the home health program, and there is no prior hospitalization requirement. When an individual is covered under parts A and B of the Medicare program, the individual will generally receive payment for home health services under part A of the program.

Home health services are covered under Medicare if the services: are ordered by, and included in the plan of treatment established by, the physician; are skilled nursing care required on an intermittent basis; are performed by or under the direct supervision of a licensed nurse; and are reasonable and necessary for the treatment of an illness or injury.

To meet the requirement for intermittent skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. Guidelines generally define "intermittent" as permitting daily skilled nursing visits for up to eight hours a day for up to two to three weeks if medically reasonable and necessary. "Daily" is defined as 5 days per week.

Reimbursement to home health agencies is based on Medicare rules for reasonable cost reimbursement. However, home health agencies are required to use the cost per visit by type of service for apportioning costs. Under this method, the total allowable costs of all visits for each type of service (skilled nursing, home health aide, etc.) is divided by the total number of visits by type of service. These average cost per visit amounts are multiplied by the number of covered Medicare visits for each type of service. The products represent the cost Medicare will recognize by type of service, subject to home health agency cost limits.

The Medicare home health benefit is the fastest growing part of the Medicare program. Table 8 below indicates the increase in Medicare program expenditures for home health care.

TABLE 8.—TOTAL MEDICARE HOME HEALTH BENEFIT PAYMENTS

[Dollars in millions] [1]

	Reimbursements			Percent change	Visits per 1,000 enrollees [2]	Average charge per visit [2]
	Part A	Part B	Total			
1969	NA	NA	$81	.....	424	$10
1970	NA	NA	63	−22.7	291	12
1971	NA	NA	57	−8.8	226	13
1972	NA	NA	66	15.7	241	14
1973	NA	NA	93	40.9	265	15
1974	NA	NA	139	48.6	340	17
1975	NA	NA	215	551	431	20
1976	NA	NA	297	38.1	520	22
1977	NA	NA	371	24.9	597	25
1978	NA	NA	443	19.4	639	27
1979	NA	NA	542	22.4	717	30
1980	NA	NA	666	22.9	792	33
1981	NA	NA	860	29.1	902	36
1982	NA	NA	1,121	30.3	1,060	40
1983	NA	NA	1,425	27.1	1,252	43
1984	NA	NA	1,897	33.1	1,352	50
1985	NA	NA	2,290	20.7	1,432	54
1986	$2,527	$32	2,559	11.7	1,485	58
1987	2,878	36	2,914	13.9	1,557	60
1988	3,171	41	3,212	10.2	1,617	63
1989	3,519	46	3,565	11.0	1,664	67
1990	3,872	52	3,924	10.1	1,696	71
1991	4,235	58	4,293	9.4	1,725	75
1992	4,594	64	4,658	8.5	1,742	79

[1] Based on FY 1988 budget assumptions, supplied by the Health Care Financing Administration.
[2] Based on part A alone.
NA = Not available.

Source: Health Care Financing Administration, Bureau of Data Management and Statistics.

5. Hospice care

Public Law 97-248 authorized Medicare part A coverage for hospice care services provided to individuals who are entitled to Medicare part A benefits and who are certified to be terminally ill. In 1986, the Congress in Public Law 99-272 made the hospice benefit a permanent part of the Medicare program effective April 7, 1986.

On December 16, 1983, the Health Care Financing Administration (HCFA) published regulations to implement the hospice provisions of Public Law 97-248. Among other things, the regulations establish requirements for eligibility, covered benefits, services, reimbursement procedures, and the conditions a hospice must meet to be approved for participation in the Medicare program.

Part A beneficiaries may elect to receive hospice care in lieu of most other Medicare benefits for up to two periods of 90 days each, plus an additional 30 days.

The statute provides that payment to hospice providers be equal to the costs which are reasonable and related to the cost of providing hospice care, or which are based on such other tests of reasonableness as the Secretary may prescribe, subject to a "cap amount." The cap amount for a beneficiary for a year was established at $6,500, adjusted annually by the medical component of the CPI. The cap for fiscal year 1987 is $7,300.

HCFA has implemented a prospective payment methodology for hospice care. Under this methodology, hospices would be paid one of four predetermined rates for each day a Medicare beneficiary is under the care of the hospice. The rates would vary according to the level of care furnished to the beneficiary. Total reimbursement to a hospice for care furnished to the Medicare beneficiary would vary by the length of the patient's period in the hospice program as well as by the characteristics of the services (intensity and site) furnished to the beneficiary.

Table 9 shows the growth of the hospice care program.

TABLE 9.—MEDICARE HOSPICE PROGRAM DATA

Period	Number of facilities	Number of admissions	Total dollars (in millions)	Reimbursement per admission
11/01/83–09/14/84	119	2,098	$3.5	$1,646
11/01/83–12/19/84	153	3,800	7.0	1,834
11/01/83–04/30/85	171	7,549	16.0	2,117
11/01/83–07/31/85	200	11,014	23.5	2,137
11/01/83–09/30/85	233	14,874	33.8	2,272
11/01/83–10/31/86	279	34,865	102.2	2,930

Source: Health Care Financing Administration, derived from Hospice Status Report.

6. Mental health services

Part A coverage of inpatient psychiatric hospital services is limited to 190 days during a person's lifetime. This limit applies only to services furnished in a psychiatric hospital, not to a psychiatric unit of a general hospital.

A special limit applies to coverage of individuals who are impatients of psychiatric hospitals at the time of entitlement (i.e., generally when they reach age 65). Under this restriction, the number of days a patient was in a psychiatric hospital within the 150 days before their entitlement is subtracted from the 150 days of inpatient hospital coverage that would otherwise be available during the first benefit period; however, these days are not subtracted from the 190-day lifetime limit.

The part B program has a special payment limit for coverage of certain outpatient mental health services rendered by physicians (either psychiatrists or other physicians). The limit applies to treatment services (not to initial diagnostic services) for a mental, psychoneurotic, or personality disorder of an individual who is not an

inpatient of a hospital at the time such expenses are incurred. The maximum reimbursement for services is $250 per calendar year for each Medicare beneficiary. Medicare recognizes a maximum of 62.5 percent of $500 of charges, or $312.50, and will reimburse 80 percent of this amount, or $250. Consequently, the effective coinsurance rate is 50 percent for the first $500.

7. Blood payments

Part A does not provide payments for the first three pints of whole blood (or the equivalent number of units of packed red blood cells) furnished to a beneficiary in a benefit period. Payments for blood processing (e.g., typing or transfusing blood) and for components of blood other than packed red blood cells (e.g., blood plasma or platelets, considered to be biologicals) are covered without applying this "blood deductible." To count toward the part A blood deductible and to be covered under part A, the blood must be furnished on a day of inpatient hospital services or extended care services.

The part B blood deductible applies to the first three pints of whole blood (or the equivalent number of units of packed red blood cells) furnished to a beneficiary in a calendar year. To count toward the part B blood deductible and to be covered under part B, the blood must be furnished in an outpatient setting incident to physician services.

The part A and part B blood deductibles are applied separately. The provider may not charge the beneficiary or a third party for blood subject to the part A or part B blood deductible if the patient, another individual, or a blood bank replaces the blood or arranges to have it replaced.

8. Prescription drugs

Inpatient prescription drugs are generally covered by Medicare if they: are ordinarily furnished by the hospital or skilled nursing facility for the care of inpatients; represent a cost to the hospital or skilled nursing facility; are for the inpatient's use in the hospital or skilled nursing facility, or are medically necessary for the patient's discharge; and are (with certain exceptions) included in an official drug compendium.

Outpatients prescription drugs are generally not covered by Medicare. Part B coverage is generally limited to drugs which are administered by injection by a physician or a nurse. However, injections that are usually self-administered (e.g., insulin) are not covered under Medicare's part B (except for drugs such as insulin when administered in an emergency, and blood clotting factors for certain hemophilia patients). Pills and other oral medications are also excluded from part B coverage because they are self-administered. The drugs must also be considered incident to a physician's services. Drugs purchased by or dispensed to a patient are not covered under part B.

Vaccinations against pneumococcal pneumonia and hepatitis B are covered. Most other immunizations are excluded. For example, preventive immunizations (e.g., for smallpox) and influenza vaccinations are not covered. Immunizations may be covered, however, if they are directly related to the treatment of an injury or direct

exposure to a disease or condition (e.g., antirabies treatment or tetanus antitoxin).

Immunosuppressive drugs (e.g., cyclosporine) are covered for 1 year after a Medicare-covered organ transplant.

9. Long-term care

Medicare does not offer protection against expenses associated with the use of long-term care services required by chronically ill persons over an extended period of time.

The range of chronic illnesses and conditions resulting in the need for long-term care services is extensive. Unlike acute care illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically, except to maintain the status quo of the patient.

These conditions may include heart disease, strokes, arthritis, and vision and hearing impairments. Dementia, the chronic often progressive loss of intellectual function, is also a major cause of disability and need for long-term care. At least half, and perhaps as many as 70 percent, of patients with dementia have Alzheimer's disease, a chronic progressive neurologic degeneration of unknown cause, which increases in prevalence with advanced age and for which there is currently no effective treatment.

To the extent that Medicare covers nursing home or home health services, it does so only where a need for skilled care is demonstrated.

Program coverage of nursing home care, for instance, is limited to short-term post-hospital stays in skilled nursing facilities (SNFs). As a result of this restriction, Medicare covered only 2 percent of the nursing home costs of the aged in 1984.

Home health care is covered only when the beneficiary can be shown to need intermittent skilled nursing care or physical or speech therapy. Many chronically ill persons do not need skilled care to remain in their homes, but do need custodial care and assistance with daily routines (such as shopping, cooking, cleaning) or other basic self-care functions (such as bathing or dressing). A beneficiary requiring only this kind of assistance cannot qualify for Medicare's home health care benefit.

D. Administration

Responsibility for administration of the Medicare program has been delegated by the Secretary of Health and Human Services to the Administrator of the Health Care Financing Administration (HCFA). Much of the day-to-day operational work of the program is performed by "intermediaries" and "carriers" which have responsibility for reviewing claims for benefits and making payments. Medicare administrative costs amount to approximately 2.5 percent of program outlays.

E. Financing

The Medicare part A Hospital Insurance Trust Fund (HI) finances inpatient hospital, skilled nursing facility, home health and other institutional services. The part B Supplementary Medical In-

surance Trust Fund (SMI) finances principally physician and hospital outpatient services.

The Hospital Insurance Trust Fund is financed primarily through Social Security payroll tax contributions paid by employers, employees, and the self-employed. The payroll tax rate for calendar year 1987 is 1.45 percent of earnings up to $43,800 per employee. An equal contribution rate is paid by the employer. Table 10 shows the contribution rates and maximum taxable earnings for both HI and the old-age, survivors and disability insurance (OASDI) programs.

TABLE 10.—CURRENT LAW SOCIAL SECURITY PAYROLL TAX RATES FOR EMPLOYERS AND EMPLOYEES EACH AND TAXABLE EARNINGS BASES

Calendar year	Employee and employer rates, each (percent)			Taxable earnings base	Maximum HI tax
	OASDI combined	HI	OASDHI combined		
1977	4.95	0.90	5.85	$16,500	$148.50
1978	5.05	1.10	6.05	17,700	194.70
1979	5.08	1.05	6.13	22,900	240.45
1980	5.08	1.05	6.13	25,900	271.95
1981	5.35	1.30	6.65	29,700	386.10
1982	5.40	1.30	6.70	32,400	421.20
1983	5.40	1.30	6.70	35,700	464.10
1984	5.70	1.30	7.00	37,800	491.40
1985	5.70	1.35	7.05	39,600	534.60
1986	5.70	1.45	7.15	42,000	609.00
1987	5.70	1.45	7.15	43,800	635.10
1988	6.06	1.45	7.51	(1)	(1)
1989	6.06	1.45	7.51	(1)	(1)
1990 and after	6.20	1.45	7.65	(1)	(1)

[1] The maximum earnings subject to the tax increases each year in accordance with the increase in average earnings.

Those who are uninsured under part A may elect to enroll by paying the full cost of coverage. The cost of the monthly premium for calendar year 1987 is $226.

Part B, which is voluntary, is financed from premiums paid by the aged, disabled and chronic renal disease enrollees and from the general revenues. The premium rate is derived annually based upon the projected costs of the program for the coming year. Under prior law, the premium rate was changed on July 1 of each year. The Social Security Amendments of 1983 (Public Law 98-21) moved the premium increase date to January 1 of each year to coincide with the changed date for the annual Social Security cash benefit cost-of-living (COLA) increase.

Ordinarily, the premium rate is the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the COLA provisions of

the Social Security program. Premium income, which originally financed half of the costs of part B, had declined—as a result of this formula—to less than 25 percent of total program income.

The Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248), temporarily suspended the COLA limitation for 2 years—calendar years 1984 and 1985. During this period, enrollee premiums were allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The Deficit Reduction Act of 1984 (Public Law 98-369) extended the TEFRA provision through calendar years 1986 and 1987. The premium beginning January 1, 1987, is $17.90 per month.

As noted above, the premiums paid by part B enrollees finance one-quarter of the cost of the program. The remaining cost is financed from the Federal general revenues.

Table 11 shows the sources of income for both the Hospital Insurance and Supplementary Medical Insurance Trust Funds.

TABLE 11.—SOURCES OF TRUST FUND INCOME, 1987

Income sources	Percent of income
Hospital Insurance Trust Fund income:	
Payroll taxes	92.1
Interest payments	6.1
Transfers and premiums [1]	1.8
Total	100.0
Supplemental Medical Insurance Trust Fund income:	
General revenues	72.2
Enrollee premiums	23.2
Interest payments	4.6
Total	100.0

[1] Transfers from the Railroad Retirement Account and the general fund of the Treasury (in accordance with provisions for the collection of taxes from railroad workers, the collection of taxes on deemed military service wage credits, and reimbursement to the fund for benefits for certain uninsured persons), and premiums paid by voluntary enrollees.

Source: 1987 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, prepared by the Health Care Financing Administration, Office of the Actuary.

The Hospital Insurance Trust Fund balances are dependent upon the income to the trust fund primarily from payroll taxes exceeding the outlays for Medicare benefits and administrative costs. Outlays are affected by increases in inpatient hospital expenditures, which have been rising at a faster rate than the income to the HI trust fund.

Due to this excess of outlays over income, the HI trust fund faces serious financial difficulties in the future. In their 1987 Annual Report, the Board of Trustees of the HI trust fund made projections based on four alternative sets of assumptions: optimistic (alternative I), two intermediate sets (alternatives II-A and II-B), and pessimistic (alternative III). The most cited set of assumptions is alter-

native II-B. According to projections based on this set of assumptions, under current policy, the trust fund is expected to be depleted in 2002. Table 12 shows these projections.

TABLE 12.—ESTIMATED OPERATIONS OF THE HOSPITAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1986–2002

[Dollar amounts in billions]

Calendar year	Total income	Total disbursements	Interfund borrowing transfers [1]	Net increase in fund	Fund at end of year	Ratio of assets to disbursements (percent) [2]
1986 [3]	$59.3	$50.4	$10.6	$19.5	$40.0	41
1987	63.3	49.1		14.2	54.1	81
1988	67.4	56.0		11.4	65.5	97
1989	72.0	61.6		10.4	75.9	106
1990	77.3	68.4		8.9	84.8	111
1991	82.7	75.4		7.4	92.1	112
1992	88.3	82.6		5.7	97.8	112
1993	93.7	90.1		3.7	101.5	109
1994	99.3	98.0		1.2	102.7	103
1995	104.9	106.5		−1.6	101.1	96
1996	110.7	115.2		−4.5	96.6	88
1997	116.7	124.3		−7.7	88.9	78
1998	122.8	134.2		−11.4	77.5	66
1999	129.2	144.9		−15.7	61.8	53
2000	135.8	156.4		−20.6	41.2	40
2001	142.5	168.5		−26.1	15.2	24
2002	149.3	181.4		−32.1	(4)	8

[1] A loan of $12.4 billion to the OASI trust fund was made in 1982. This loan was still an asset of the HI trust fund; however, since these assets were not immediately available for payment of HI benefits, they were substracted from the HI fund balance. The positive amounts shown represent repayments of principal to the HI trust fund.

[2] Ratio of assets in the trust fund at the beginning of the year to disbursements during the year.

[3] Figures for 1986 represent actual experience.

[4] Trust fund depleted in calendar year 2002.

Notes: The above estimates are based on 1987 alternative II-B assumptions. Totals do not necessarily equal the sum of rounded components.

Source: 1987 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, prepared by the Health Care Financing Administration, Office of the Actuary.

Longer-term projections of trust balances depend on many different assumptions. Changes in the prospective payment system rates, the number of Medicare beneficiaries, the inpatient hospital admission rates, and the complexity of diagnosis (i.e., severity of illness) can increase or decrease trust fund outlays. Finally, forecasting changes in medical technology and their implications for spending is very difficult.

Long-range estimates for the next 25 years are shown in table 13 for the HI program and are based on the alternative II-B assumptions. Annual expenditures as a percentage of taxable earnings are shown in table 13 as the cost rate. The income rate for the HI pro-

gram is simply the combined scheduled tax rate for employees and employers.

The average deficit over the 25-year period is 0.44 percent of taxable earnings. Last year, the 25-year average deficit was estimated to be 0.66 percent of taxable earnings. Nevertheless, near the end of the 25-year period, either the tax rate must increase substantially or costs must decline for the trust fund to remain solvent under these assumptions.

TABLE 13.—COST AND TAX RATES OF THE HOSPITAL INSURANCE PROGRAM AS A PERCENT OF TAXABLE PAYROLL

Calendar year	Expenditures under the program [1]	Trust fund maintenance [2]	Total cost of the program [3]	Tax rate scheduled in the law [4]	Difference
1987	2.57	0.33	2.90	2.90	0.00
1988	2.63	.27	2.90	2.90	.00
1989	2.73	.17	2.90	2.90	.00
1990	2.84	.06	2.90	2.90	.00
1995	3.22	−.32	2.90	2.90	.00
2000	3.48	.03	3.51	2.90	−.61
2005	3.73	.02	3.75	2.90	−.85
2010	4.01	.01	4.02	2.90	−1.12
25-year average: 1987–2011	3.39	−.05	3.34	2.90	−.44

[1] Costs attributable to insured beneficiaries only. Benefits and administrative costs for noninsured persons are financed through general revenue transfers and premium payments, rather than through payroll taxes. Gratuitous credits for military service after 1956 are included in taxable payroll.

[2] Allowance for maintaining the trust fund balance at the level of at least a half-year's outgo after accounting for the offsetting affect of interest earnings.

[3] Totals do not necessarily equal the sum of rounded components.

[4] Rates for employees and employers combined.

Notes: The above estimates are based on alternative II-B assumptions. Taxable payroll is adjusted to take into account the lower contribution rates on tips and on multiple-employer "excess wages," as compared with the combined employer-employee rate.

Source: 1987 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, prepared by the Health Care Financing Administration, Office of the Actuary.

Because the Supplementary Medical Insurance Trust Fund (SMI) is financed through beneficiary premiums and general revenues, it does not farce the prospect of depletion as does the HI trust fund. However, the rapidly rising cost of health care is placing a heavy burden on the SMI trust fund, causing beneficiary premiums to rise and increasing the Federal deficit. In their 1987 Annual Report, the Board of Trustees of the SMI trust fund projects that its outlays will increase at an annual rate of about 15 percent from 1987 through 1989.

F. Out-of-Pocket Liabilities of Medicare Beneficiaries

Although Medicare covers most of the costs of serious illnesses, beneficiaries are responsible for a portion of their health care expenditures on covered services. These enrollee liabilities include Medicare copayments—deductibles and coinsurance under both

Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)—and balance-billing by physicians who charge in excess of Medicare's allowed amounts.

In 1987, these out-of-pocket liabilities will average $561 per enrollee (see table 14). On average, 65 percent of copayment costs arise under the SMI program and 35 percent arise under the HI program. More than 50 percent of copayment costs are on the claims of physicians and related suppliers. When balance-billing is considered as well, more than 60 percent of out-of-pocket costs are on physicians' claims. About a third of copayment costs are on hospital inpatient stays, while less than 2 percent is due to coinsurance on stays in skilled nursing facilities or on hospice or home health services. Nearly 14 percent of copayment costs arise in hospital outpatient departments.

Copayment liabilities are highest for enrollees with inpatient stays, and for those with renal disease. Those with hospital inpatient stays comprise 22 percent of the enrollee population, but this group is liable for 70 percent of out-of-pocket costs (see table 15). Enrollees with renal disease are only 0.4 percent of the enrollee population, but they are liable for nearly 4 percent of out-of-pocket costs.

TABLE 14.—MEDICARE ENROLLEES' OUT-OF-POCKET LIABILITIES FOR COVERED SERVICES, BY TYPE OF SERVICE, 1987 [1]

Type of service	Medicare copayments		Balance-billing		Total	
	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total
Total Medicare	456	100.0	105	100.0	561	100.0
Hospital insurance	159	35.0	0	0.0	159	28.4
Inpatient stays	151	33.1	0	0.0	151	26.9
Other	8	1.8	0	0.0	8	1.5
Supplementary medical insurance	296	65.0	105	100.0	401	71.6
Physicians/suppliers	235	51.5	105	100.0	340	60.6
Outpatient departments	62	13.5	0	0.0	62	11.0

[1] The costs shown here represent aged and disabled enrollees' liabilities. Amounts paid by enrollees may be less, because some enrollees' liabilities are paid by Medicaid or are not paid at all.

Source: Preliminary Congressional Budget Office estimates based on 1985 Medicare claims data, projected to 1987.

Only about 20 percent of aged Medicare enrollees actually pay these out-of-pocket liabilities directly, though. Medicare copayment costs are paid by Medicaid for the 8 percent of enrollees who are dually eligible. Another 72 percent of enrollees have medigap insurance that pays most of their Medicare copayment costs, in exchange for additional premiums that will average between $500 and $600 in 1987. As a result, enrollees' actual payments (including both out-of-pocket costs and medigap insurance premiums) are much more uniform across types of enrollees than is apparent in table 15.

TABLE 15.—MEDICARE ENROLLEES' OUT-OF-POCKET LIABILITIES FOR COVERED SERVICES, BY TYPE OF ENROLLEE, 1987 [1]

Enrollee group	Percent of enrollees in group	HI copayments		SMI copayments		Balance-billing		Total	
		Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total	Dollars per enrollee	Percent of total
All enrollees	100.0	159	100.0	296	100.0	105	100.0	561	100.0
Male	42.3	163	43.2	305	43.5	114	45.8	581	43.9
Female	57.7	157	56.8	290	56.5	99	54.2	546	56.1
Under age 65	9.9	176	11.0	369	12.4	65	6.1	609	10.8
Age 65 to 69	33.2	112	23.3	247	27.7	99	31.2	457	27.1
Age 70 to 74	18.3	146	16.8	292	18.1	116	20.3	555	18.1
Age 75 to 79	17.5	173	19.0	321	19.0	126	21.0	620	19.4
Age 80 to 84	11.4	209	14.9	332	12.8	118	12.8	659	13.4
Age 85 or more	9.6	249	15.0	312	10.1	95	8.7	656	11.2
Aged:									
Without renal disease	90.4	156	88.4	281	85.7	109	93.8	546	88.0
With renal disease	0.1	856	0.7	4,643	2.1	234	0.3	5,733	1.4
Disabled:									
Without renal disease	9.2	172	9.9	273	8.5	64	5.6	508	8.4
With renal disease	0.3	550	0.9	4,109	3.7	138	0.4	4,796	2.3
No reimbursable services	28.4	0	0.0	37	3.6	0	0.0	37	1.9
Reimbursable services, with:									
No inpatient stays	49.7	1	0.4	243	40.8	73	34.3	317	28.1
One stay	14.5	520	47.4	563	27.6	252	34.8	1,335	34.6
Two or more stays	6.9	827	35.7	1,079	25.0	440	28.8	2,346	28.8
One or more stays, with coinsurance days	0.5	5,391	16.5	1,809	3.0	457	2.1	7,657	6.7

[1] The costs shown here represent aged and disabled enrollees' liabilities. Amounts paid by enrollees may be less, because some enrollees' liabilities are paid by Medicaid or by supplementary private insurance, or some liabilities are not paid at all. For those enrollees who purchase medigap insurance, the burden of costs (including both out-of-pocket costs and medigap insurance premiums) is more uniform across types of enrollees than shown here, because medigap coverage greatly reduces enrollees' copayment costs in return for their paying private insurance premiums.

Source: Preliminary Congressional Budget Office estimates based on 1985 Medicare claims data, projected to 1987.

According to a report by the General Accounting Office (Medicare and Medicaid: Effects of Recent Legislation on Program and Beneficiary Costs, April 1987, GAO/HRD-87-53), the 1985 constant dollar average out-of-pocket costs paid by a beneficiary for covered Medicare services has increased a total of $162 in recent years.

Part A 1985 constant dollar average out-of-pocket costs per enrollee—including the deductible and coinsurance costs for inpatient hospital and skilled nursing facility care—increased $41, from $84 in 1980 to $125 in 1985.

Part B 1985 constant dollar average out-of-pocket costs per enrollee—including the deductible, coinsurance, premiums, and reasonable charge reductions for unassigned claims—increased $121, from $395 in 1980 to $516 in 1985.

SECTION III. OTHER HEALTH INSURANCE COVERAGE OF THE ELDERLY

A. General Information

Nearly all of the elderly (99 percent) are covered for some medical expenses under at least one type of health insurance, with over 96 percent of them covered under Medicare. Because the remaining out-of-pocket liabilities for Medicare's covered services (for example, deductibles and coinsurance) and some health care services are not covered by Medicare, over 20 million, or 80 percent, of the elderly have additional coverage through either private supplementary insurance or Medicaid.[1]

As figure 1 shows, in 1984, 18 million—or 72 percent—of the elderly were covered by some form of private supplementary insurance, either as part of a group (generally insured through their current or former employer or union) or under an individual policy. There is considerable variation in the benefits offered under these policies, ranging from the conventional employer-provided insurance held by the working aged to hospital indemnity plans that pay only a limited sum for each day of hospitalization.[2]

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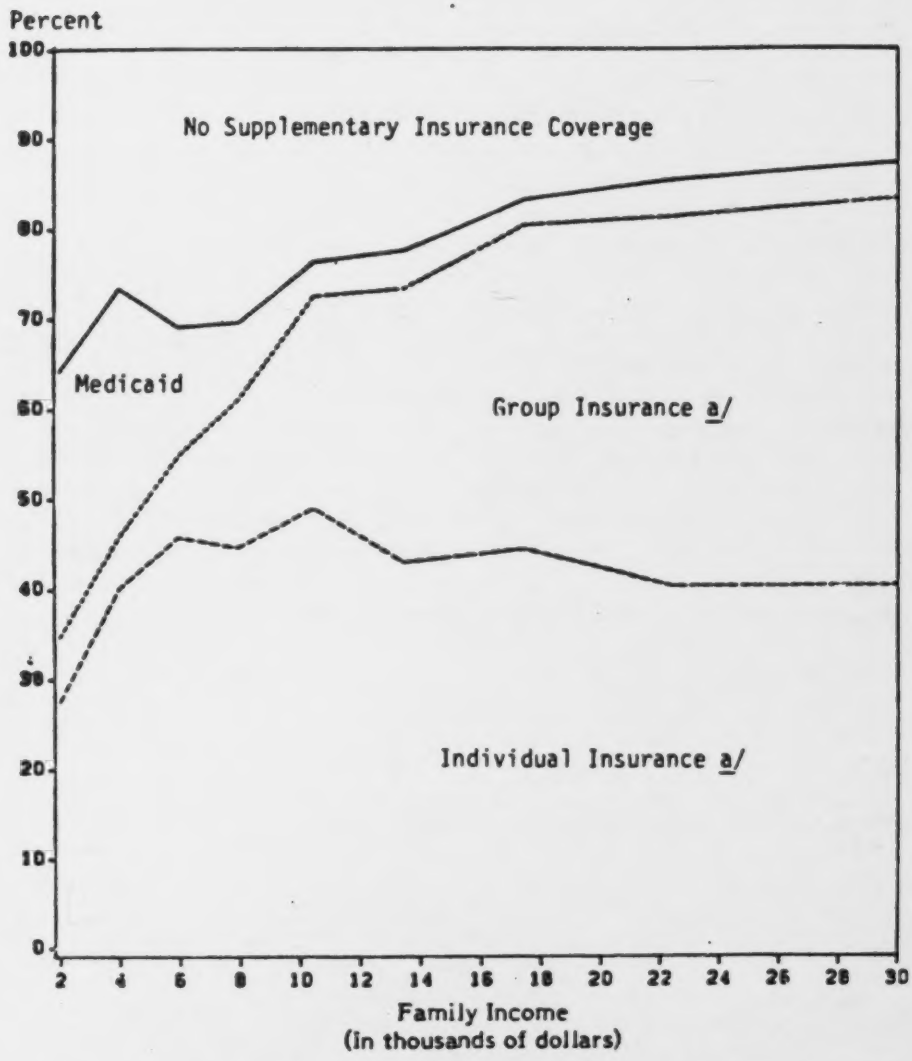
[1] Most of the estimates in this section are based on the April 1984 Survey of Income and Program Participation (SIPP), which covers the civilian, noninstitutional population of the United States. Therefore, about one million institutionalized elderly, many covered by Medicaid, are excluded from this discussion of supplementary insurance. Individuals who have both private policies and Medicaid eligibility are included in the Medicaid category.

[2] The situation differs for those elderly under age 70 who are employed and covered by their employers' health plan, and for spouses under 70 who are covered by plans of workers under age 70. These private insurance plans must pay all bills that they cover, with Medicare serving as a secondary payer. Little is known about these beneficiaries or the characteristics of these plans.

FIGURE 1. PERCENT OF ELDERLY MEDICARE ENROLLEES HAVING SUPPLEMENTARY INSURANCE COVERAGE, BY FAMILY INCOME, APRIL 1984



SOURCE: Congressional Budget Office tabulations of Survey of Income and Program Participation (SIPP).

a. The SIPP questionnaire allows for description of only one type of private insurance plan. The first descriptive question asks whether it was an employer or union plan. Therefore, people who were covered under both a group and an individual plan are likely to have been classified above as covered by group insurance.

B. MEDIGAP

The most common form of private coverage supplementary to Medicare is the "medigap" policy, which is designed to pay part or all of Medicare's deductible amounts and coinsurance. Consequently, medigap policies reduce the risks of high out-of-pocket expenditures associated with Medicare's covered services, although most policies do not cover other costs such as those for prescription drugs or long-term care.

Under current law, Medicare supplemental health insurance policies (medigap policies) must meet minimum standards before companies can market them as medigap policies. The standards are contained in a model regulation approved by the National Association of Insurance Commissioners (NAIC) on June 6, 1979, and incorporated in section 1882 of the Social Security Act. This section is commonly called the Baucus Amendment.

The standards contained in section 1882 require medigap policies to: (1) cover all of the Medicare part A inpatient coinsurance for the 61st through the 90th day in the hospital, and the 91st through 150th day lifetime reserve days, plus 90 percent of covered hospital inpatient expenses for a lifetime maximum of up to 365 days after the insured has exhausted Medicare benefits; (2) cover the Medicare part B coinsurance, which may be subject to a $200 deductible and a maximum benefit of $5,000 per year; (3) cover the part A and B blood deductibles; (4) not define preexisting conditions more restrictively than as a condition that was diagnosed or treated within 6 months before the effective date of the policy; (5) automatically change as Medicare's deductibles and coinsurance requirements change; (6) have a "free look" period, during which an individual may return an unwanted policy for cancellation and receive a full refund of any premium paid; (7) provide cancellation and termination clauses to be prominently displayed; and (8) at the time of the sale, provide a buyers guide explaining benefits and limitations of Medicare and Medicare supplemental insurance.

In addition, medigap policies are required to meet certain loss ratio targets, which are the percentage of insurance premiums returned to policyholders in the form of benefits. Loss ratios are calculated by dividing the amount of incurred claims by the amount of earned premiums. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies.

There are Federal sanctions, consisting of fines and/or imprisonment, for (1) furnishing false information to obtain the Secretary's certification, (2) posing as a Federal agent to sell medigap policies, (3) knowingly selling policies that duplicate coverage the individual already has, and (4) selling supplemental policies by mail in States that have not approved, or are deemed not to have approved, their sale.

In a report on the effectiveness of section 1882 (Medigap Insurance, October 1986, GAO/HRD-87-8), the General Accounting Office found that 46 States, Puerto Rico, and the District of Columbia have laws and regulations that meet the section's minimum requirements. GAO found that the 1982-84 cumulative loss ratios for the companies surveyed ranged from a low of 18.6 percent to a high

of 111.8 percent for individual policies. Of the 376 individual policies of commercial insurers that GAO studied, the average 1984 loss ratio was 60.2 percent. The 1984 loss ratio for individual policies sold by Blue Cross/Blue Shield plans was 81.1 percent. GAO found that the actual loss ratios of many of the medigap policies did not meet the target loss ratios of section 1882, but the actual loss ratios of the policies with the largest volumes of earned premiums were above the targets. GAO computed loss ratios for 394 individual and 4 group medigap policies and found that 254 policies (64 percent) were below the loss ratios targets. However, these policies had about $650 million in earned premiums in 1984, compared to $1.4 billion for the 144 policies (36 percent) whose loss ratios were above the target. The overall actual loss ratios for the companies studied equaled only 60 percent. (See table 1 below.)

TABLE 1.—LOSS RATIO EXPERIENCE OF SELECTED MEDIGAP INSURANCE POLICIES

Range of 1984 earned premium and type	Number of policies with cumulative loss ratios	
	Above target	Below target
Over $100 million:		
Individual:		
Commercial	1	0
Blue Cross/Blue Shield	3	0
$50 to $99 million:		
Individual:		
Commercial	1	2
Blue Cross/Blue Shield	2	0
$1 to $49 million:		
Individual:		
Commercial	39	89
Blue Cross/Blue Shield	10	2
Group	1	1
Under $1 million:		
Individual:		
Commercial	86	158
Blue Cross/Blue Shield	1	0
Group	0	2
Total	144	254

Source: General Accounting Office, "Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies," October 1986 (GAO/HRD–87–8), p. 28.

To obtain medigap coverage, the elderly (or an employer or union) must pay a premium reflecting the scope of the benefit package, as well as administrative and marketing costs that ranged from 15 percent to 35 percent of the premium. Annual medigap premiums averaged roughly $300 to $400 per person in 1984, though as a result of considerable differences in benefits and administrative costs they ranged from as low as $150 to over $1,000.

The likelihood of an elderly person having private insurance rises with family income. As figure 1 also shows, 44 percent of

those with incomes under $5,000 were covered, compared with 87 percent of those with incomes of $25,000 or more. Group insurance was more likely among those who had higher incomes, were younger, lived with their spouses, or were employed; ownership of individual policies was more evenly distributed.

C. Medicaid

According to Congressional Budget Office estimates, 2.4 million aged and disabled Medicare enrollees are also covered by State Medicaid programs. All State Medicaid plans, except for the Wyoming plan, pay the monthly Medicare part B premium payment for these dual eligible beneficiaries under a "buy-in" agreement.

Eligibility for Medicaid is linked to actual or potential receipt of cash assistance. For the aged and disabled, such assistance is obtained through the Federal Supplemental Security Income (SSI) program.

All States cover the "categorically needy" under their Medicaid plans. In general these are persons receiving cash assistance, although under certain circumstances States have the option of imposing more restrictive criteria for Medicaid eligibility than for cash assistance. A State choosing the more restrictive criteria must allow applicants to deduct medical expenses from income in determining eligibility.

States may cover additional groups of persons as categorically needy. These include persons eligible for but not receiving cash payments and individuals eligible for assistance except for their institutional status. States may also extend Medicaid to persons receiving optional supplementary cash payments. States electing to make these optional payments may limit them to reasonable classifications of categorically related individuals (e.g., the aged, the institutionalized). The income standard used for this purpose cannot exceed 300 percent of the SSI benefit payment amount. In practice, this authority is generally utilized to extend coverage to persons in skilled nursing or intermediate care facilities.

States may also cover the "medically needy" under their Medicaid programs. These are persons whose income and/or resources are slightly in excess of the standards for cash assistance provided: (1) they would otherwise meet the criteria for cash assistance, and (2) their income, after deducting incurred medical expenses, falls below the State standard.

While States may "buy-in" to part B of Medicare for both their cash assistance and noncash assistance populations who are eligible for Medicare, Federal matching for premium payments is available only for the cash assistance group. If a State does not buy-in for part B coverage, it cannot receive Federal matching payments for medical services which would have been covered under Medicare if there had been a buy-in arrangement. Some States also pay some or all of the Medicare coinsurance (generally 20 percent of the "reasonable charge") and deductible amounts.

Once covered by Medicaid, an elderly person faces little risk of high out-of-pocket expenses—the SMI premium and Medicare's cost sharing requirements are generally paid by Medicaid. Moreover, physicians who treat Medicaid patients may not bill these patients

for any charges not paid by Medicare or Medicaid. Finally, many States cover a wide range of additional services as optional benefits that further reduce the risks to these elderly—48 of 50 Medicaid programs covered prescription drugs in 1981, for example.

About 5 million—or 20 percent—of elderly Americans had no protection other than Medicare against health care costs. Moreover, the elderly with lower incomes and with greater health care needs were most likely to lack insurance supplementary to Medicare, as shown in table 2. For example, nearly 30 percent of the elderly with family incomes under $9,000 had neither private coverage nor Medicaid eligibility, compared with 10 percent of those with family incomes over $25,000. Although health care needs rise with age, so did the likelihood of being without supplementary insurance—17 percent of those between 65 and 69 lacked coverage, compared with 27 percent of those 80 and older. Finally, lack of supplementary coverage was not related to health status, largely because Medicaid covers many of the elderly who are most likely to have poor health. Among those who were not eligible for Medicaid, however, those in poor health were least likely to have private insurance—28 percent were not covered, compared with 20 percent for those whose health was good or excellent.[1]

TABLE 2.—CHARACTERISTICS OF ELDERLY MEDICARE ENROLLEES, APRIL 1984 [1]

Characteristic	Number of enrollees (in millions)	Percent of enrollees	Percent having neither private supplementary coverage nor Medicaid eligibility
All [2]	25.6	100	20.1
Family Income			
Under $5,000	3.1	12.2	28.5
$5,000 to $8,999	5.6	21.8	29.9
$9,000 to $14,999	6.2	24.1	20.8
$15,000 to $24,999	5.9	22.9	13.7
$25,000 and over	4.9	19.1	10.1
Age			
65 to 69	8.6	33.3	17.3
70 to 74	7.2	28.0	19.1
75 to 79	4.9	19.3	20.1
80 and above	5.0	19.4	26.5

[1] Part of the explanation is that the decision to purchase private supplementary insurance is directly related to the ability to pay its premiums, and those with greater health care needs typically have lower incomes. Factors that lead to loss of coverage or barriers against acquiring coverage may also be important.

TABLE 2.—CHARACTERISTICS OF ELDERLY MEDICARE ENROLLEES, APRIL 1984 [1]—Continued

Characteristic	Number of enrollees (in millions)	Percent of enrollees	Percent having neither private supplementary coverage nor Medicaid eligibility
Self-Reported Health Status			
Excellent	6.6	25.6	19.5
Good	9.5	37.1	20.1
Fair	6.4	25.2	20.4
Poor	3.1	12.1	20.8

[1] Details may not add to totals because of rounding.
[2] These estimates apply to the civilian, noninstitutionalized population age 65 and over enrolled in Medicare.

Source: Congressional Budget Office calculations based on the Survey of Income and Program Participation and the 1980 National Medical Care Utilization and Expenditure Survey.

SECTION IV. H.R. 1280/H.R. 1281, AS APPROVED BY THE SUBCOMMITTEE ON HEALTH

A. Bill Descriptions

This section provides a summary of H.R. 1280 (the Medicare Part A Catastrophic Protection Act of 1987) and H.R. 1281 (the Medicare Part B Catastrophic Protection Act of 1987) as approved by the Subcommittee on Health, Committee on Ways and Means, on April 9, 1987.

H.R. 1280

MEDICARE PART A CATASTROPHIC PROTECTION ACT OF 1987

1. Inpatient hospital services

a. Inpatient hospital deductible.—The inpatient hospital deductible would apply only to a beneficiary's first period of continuous hospitalization beginning in a calendar year.

b. Elimination of day limitation on inpatient hospital services.—The Medicare limits on payment for days of inpatient hospital care (90 days of inpatient hospital care during each spell of illness, plus a lifetime reserve of 60 days) would be eliminated so that Medicare would pay for an unlimited number of hospital days for covered services. The 190-day lifetime limit and 150 day rule on inpatient psychiatric hospital services would be retained.

c. Elimination of coinsurance amounts for inpatient hospital services.—The current hospital inpatient coinsurance amounts for days 61 through 90 and coinsurance for the 60 lifetime reserve days would be eliminated.

d. Indexation of inpatient hospital deductible.—The inpatient hospital deductible beginning in 1988 would be changed so that it would equal the preceding year's deductible, increased by the cost-of-living adjustment to Social Security benefits.

e. Determination of the part A premium.—The Secretary would be required to establish a part A premium for those who voluntarily enroll in part A equal to the actuarial value of the part A benefit. The actuarial value would equal one-twelfth of the estimated average per capita amount payable from the Hospital Insurance Trust Fund for services and related administrative costs incurred in the succeeding calendar year for individuals age 65 and over entitled to hospital benefits during that entire year.

f. Adjustment in payments for inpatient hospital services.—When adjusting the Medicare hospital payment system, the Secretary would be required to take into account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. The Secretary, when appropriate, would adjust the payment rates under the prospective payment system, the outlier

cutoff points, the weighting factors, and the target amounts for paying non-PPS hospitals.

2. Post-hospital extended care (skilled nursing facility) services

a. Coinsurance rate of 20 percent on first 7 days.—Beneficiaries would be required to pay coinsurance amounts for the first 7 days of SNF care each calendar year. The coinsurance amount per day would be equal to 20 percent of the national average per diem Medicare reasonable cost for SNF services in the succeeding year.

b. Cover 150 days of care.—The Medicare program would cover up to 150 days, instead of up to the current 100 days per spell of illness, of skilled nursing care services in a calendar year.

c. Eliminate hospital requirement for skilled nursing facility coverage.—The 3-day prior hospitalization requirement to receive extended care services in a skilled nursing facility would be eliminated.

3. Hospice care

a. Extention of day limit on hospice care.—The Medicare program would extend the hospice benefit for a subsequent period, and reimburse a hospice, beyond the current 210-day benefit period under certain circumstances.

b. Continued certification of terminal illness.—A subsequent extension period for the hospice benefit would be granted beyond the 210-day limit if the Medicare beneficiary was recertified as terminally ill by the attending physician or medical director.

4. Blood deductible

a. Change blood deductible requirement.—A Medicare beneficiary would be responsible for payment of a deductible equal to the expenses incurred for the first 3 pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year. The blood deductible could be met by replacing the blood, in accordance with regulations.

5. Value of Medicare coverage included in gross income

a. Subsidized value of Medicare coverage included in gross income.—The Internal Revenue Code would be amended to provide that an individual's gross income subject to taxation would include a portion of: (1) the Medicare part A (hospital insurance) actuarial values for each month that the individual was entitled to Medicare part A benefits in the calendar year, and (2) the Medicare part B (supplementary medical insurance) actuarial values for each month the individual was voluntarily enrolled for Medicare part B benefits in the calendar year.

The included portion of the Medicare benefit subject to taxation would be 50 percent of the actuarial value of part A benefits and administrative costs and approximately 75 percent of the actuarial value of part B benefits and administrative costs.

The inclusion would not apply to individuals who must pay a premium in order to receive part A coverage and to qualified nonresidents.

b. Itemized deduction for medical expenses.—The value of Medicare coverage included in gross income would be treated as an ex-

pense paid for medical care. Thus, the value of Medicare coverage included in gross income would be allowable as an itemized deduction to the extent that the taxpayer's total medical expenses (including medical expenses attributable to this provision) exceed 7.5 percent of adjusted gross income.

c. Transfer of revenues to the Federal Hospital Insurance Trust Fund.—Amounts equal to the total tax liabilities attributable to the included Medicare part A actuarial values for individuals entitled to part A of Medicare would be appropriated for, and transferred at least quarterly from the general fund of the Treasury to, the Federal Hospital Insurance Trust Fund.

d. Information reporting.—Information concerning the aggregate amounts of the included Medicare part A and part B actuarial values would be provided with respect to each Medicare beneficiary during that calendar year on the Form 1099 (relating to information on Social Security benefits).

6. Effective date

The above part A benefits (except for the elimination of the SNF 3-day prior hospitalization requirement, effective January 1, 1989) would be effective for services provided on or after January 1, 1988. Tax changes would apply to taxable years ending after December 31, 1987. With respect to the included Medicare parts A and B actuarial values, the changes would apply for months after December 31, 1987.

H.R. 1281

MEDICARE PART B CATASTROPHIC PROTECTION ACT OF 1987

1. Limitation on Medicare out-of-pocket expenses under part B

a. Limit.—For Medicare beneficiaries enrolled in part B, the following limit on out-of-pocket expenses would apply. After a Medicare beneficiary had incurred out-of-pocket part B covered expenses in a calendar year which exceeded the part B catastrophic limit, (1) Medicare would be required to pay 100 percent of the reasonable charges (or in some cases, the reasonable costs) for any additional part B covered services in the year, and (2) no further deductibles would be required.

Out-of-pocket part B expenses would be defined to include the part B $75 deductible, the part B blood deductible, $250 of reimbursable mental health services, and the 20 percent coinsurance required to be paid by beneficiaries for part B benefits.

The part B catastrophic limit would be set at $1,043 in 1989 and increased by the Social Security cost-of-living adjustment (COLA) in succeeding years.

For prepared health care organizations paid on the basis of aggregate reasonable cost, the Secretary would be required to provide for an appropriate adjustment to their payment amounts to reflect the increase in protection as if payment were made on an individual-by-individual basis.

b. Limitation on charges where catastrophic limit is reached.—Institutional providers with agreements with the Medicare program would be prohibited from charging Medicare beneficiaries for serv-

ices for which catastrophic benefit payments are made to the provider.

c. Effective date.—The effective date for the limit on out-of-pocket expenses would be for services provided on or after January 1, 1989.

2. Home health services

The "intermittent" skilled nursing care definition for home health services would be expanded so that "daily" would be defined as seven days a week for up to 35 days in any given period instead of five days a week for up to two to three weeks. A subsequent extension could be provided based on a physician's certification of exceptional circumstances requiring the continuation of services beyond the 35 consecutive days.

3. Outpatient mental health

The current law maximum Medicare reimbursement for mental health outpatient services would be raised from the current limit of $250 to $1,000 per calendar year for each beneficiary. Amounts in excess of current law reimbursable limits ($250) would not be counted towards the part B catastrophic limit. The coinsurance requirement would remain the same.

4. Notice requirement

By not later than January 1988, the Secretary would be required to distribute an annual notice, to be sent to all Medicare beneficiaries with their Social Security check or in a separate mailer to those who do not receive a Social Security check, which would provide a simple, clear explanation of Medicare benefits and exclusions. This notice would also include an explanation of the limits of the Medicare and Medicaid programs with regard to long term care benefits. In addition, a directory of participating physicians would be sent to each beneficiary each year starting in January, 1988.

5. Medicaid buy-in for poor elderly and disabled

The Federal Supplemental Security Income program (SSI) would be amended to establish a separate category of elderly and disabled for whom State Medicaid programs, including States operating under section 1115 waivers, would be required to pay the Medicare premium, deductibles, and coinsurance amounts. All elderly and disabled with incomes up to the Federal poverty level (incomes up to $5,400 for an elderly individual and $6,800 for an elderly couple) would be entitled to participate in this program.

6. Medicare part B premium increase to ensure budget neutrality

For calendar year 1988 an additional $1.30 premium per month would be paid by beneficiaries for part B benefits. For calendar years 1989 and later, as in current law, the amount of additional part B benefits included in determining the part B premium would be the same percentage increase as the increase in the cost-of-living adjustment for Social Security benefits.

7. Certification of Medicare supplemental health insurance policies

a. Establishment of new medigap standards.—The Secretary, taking into consideration any recommendations developed by the National Association of Insurance Commissioners and the Medicare catastrophic legislation passed by the Congress, would be required to report to the Congress, within 150 days after enactment of the legislation, his recommendations for changes that would be made in the Federal requirements for certification of Medicare supplemental policies.

b. Required mailing of notice.—Medicare supplemental policies in effect on January 1, 1988, would be required by January 31, 1988, on a one-time basis, to send a letter to their policyholders who are entitled to Medicare explaining the improved benefits contained in the catastrophic legislation passed by the Congress and how these improvements will affect the benefits contained in the policies and the premiums.

c. Required submission of advertising.—Medicare supplemental policies would be required to submit their advertising files to the State Insurance Commission for review as to whether their marketing practices comply with State law.

d. Transition for current policies.—Federal penalties for noncompliance with the substantial duplication of health benefits requirement contained in section 1882(d)(3)(A) would be suspended for 2 years for existing Medicare supplemental policies, but new policies would still be subject to the penalties and fines of not more than $25,000 or imprisonment for not more than 5 years, or both, after Medicare catastrophic legislation is enacted.

B. Impact of H.R. 1280/H.R. 1281 and Other Provisions As Approved by the Subcommittee on Health

1. Effect on beneficiaries

The Subcommittee on Health's proposal places limits on a Medicare beneficiary's out-of-pocket costs for Medicare-covered services, as can be seen in the following table.

TABLE 1.—1989 MAXIMUM OUT-OF-POCKET BENEFICIARY PAYMENTS FOR MEDICARE-COVERED SERVICES UNDER H.R. 1280/H.R. 1281 AS APPROVED BY THE SUBCOMMITTEE ON HEALTH

Cost-sharing by benefit	Maximum beneficiary out-of-pocket payments for Medicare-covered services
Hospital deductible (limit of 1 per year)	$565.00
SNF copayment (first 7 days)	176.40
Part B out-of-pocket cap	[1] 1,043.00
Total	[1] 1,784.40

[1] Potentially includes the 20 percent coinsurance for part B services, the part B deductible, the part B blood deductible, and $250 of a beneficiary's $1,000 out-of-pocket costs for out-patient mental health services. Does not include possible beneficiary out-of-pocket payments for (a) services Medicare does not cover (such as skilled nursing facility care after 150 days in a year or out-patient prescription drugs) or (b) charges in excess of Medicare's approved amounts on physician bills.

Source: Congressional Budget Office.

The average copayment (copayments are deductible and coinsurance amounts) to be paid by aged or disabled Medicare beneficiaries under the Subcommittee on Health's proposal is estimated by the Congressional Budget Office to be $402 in 1989, compared to $542 under current law projections for 1989. The number of Medicare beneficiaries (aged and disabled) whose 1989 copayments would be reduced under part A under the Health Subcommittee's proposal is estimated by the Congressional Budget Office to be 7,778,000 (24.0 percent of beneficiaries); the average decrease in copayments would be $602. The number of beneficiaries whose 1989 copayments would rise is estimated to be 337,000 (1.0 percent); the average increase in copayment for this 1 percent would be $406.

The number of Medicare beneficiaries (aged and disabled) who would be affected by the proposed limit on part B beneficiary cost-sharing under the Subcommittee on Health's proposal is estimated by the Congressional Budget Office to be 2.72 million (8.4 percent of beneficiaries) in 1989, 3.0 million (9.1 percent) in 1990, 3.27 (9.7 percent) in 1991, and 3.53 million (10.3 percent) in 1992.

The proposal would also increase the monthly SMI premium paid by beneficiaries enrolled in part B of Medicare. See the "Financing" section below for a description of this increase.

2. Financing

H.R. 1280/H.R. 1281 as approved by the Subcommittee on Health would cost (excluding administrative costs but including the Medicaid effect) an additional $685 million in fiscal year 1988, $3.5 billion in fiscal year 1989, and $5.3 billion in fiscal year 1990, for a 3-year total of $9.485 billion. The Medicare outlay estimates for the proposal are shown in the following table.

TABLE 2.—OUTLAY EFFECT (NET OF ADMINISTRATIVE COSTS) OF H.R. 1280/H.R. 1281 AS APPROVED BY THE SUBCOMMITTEE ON HEALTH

[In millions of dollars]

	Fiscal year—					Total, fiscal year—	
	1988	1989	1990	1991	1992	1988–90	1988–92
Catastrophic benefits [1]	700	3,240	4,940	5,990	7,075	8,880	21,945
Medicaid savings	−65	−305	−465	−560	−665	−835	−2,060
Medicaid buy-in to 100 percent	50	285	345	410	450	680	1,540
Benefit improvements [2]		280	480	595	725	760	2,080
Total outlays	685	3,500	5,300	6,435	7,585	9,485	23,505

[1] Benefits are phased-in to be deficit neutral in all years and a part of the costs are offset by a small part B premium beginning in calendar year 1988.

[2] Includes incremental improvements in home health, skilled nursing facility, and mental health benefits.

Source: Congressional Budget Office.

The Subcommittee on Health's proposal would be financed by taxing the subsidized portion of the actuarial values of the part A and part B benefits. The subsidized portion of the Medicare benefit subject to taxation would be 50 percent of the actuarial value of part A benefits and administrative costs and approximately 75 percent of the actuarial value of part B benefits and administrative costs. The Internal Revenue Code would be amended to provide that these amounts would be added to the adjusted gross income of Medicare beneficiaries subject to taxation. The following table (table 3) shows the projected actuarial values of Medicare part A and part B benefits and the portion of those values which would be included in the adjusted gross income of Medicare beneficiaries under the subcommittee's proposal.

TABLE 3.—PROJECTED ACTUARIAL VALUE OF MEDICARE BENEFITS AND PORTION INCLUDED AS INCOME FOR TAXATION PURPOSES UNDER THE SUBCOMMITTEE ON HEALTH'S PROPOSAL

Calendar year	HI (Part A)		SMI (Part B)		Total Medicare
	Actuarial value	Included portion	Actuarial value	Included portion	Included portion
1988	$1,862	$931	$1,101	$829	$1,760
1989	2,025	1,013	1,334	1,042	2,055
1990	2,221	1,110	1,492	1,189	2,299
1991	2,413	1,207	1,665	1,348	2,554
1992	2,620	1,310	1,858	1,528	2,838

Source: Congressional Budget Office.

Approximately 54 percent of Medicare-eligible filing units would pay no additional tax in 1988 under the subcommittee's proposal. (A filing unit is defined as the head of household, plus any spouse or dependents, who files a tax return. For purposes of this table, the Joint Committee on Taxation has increased the number of elderly and disabled filing units to include those who would not send in a tax return in 1988 because they have no tax liability.) For the 46 percent of filing units who would pay additional taxes, the average tax increase per Medicare beneficiary would be $148. The amount of the tax increase would vary, of course, according to the income class of the Medicare filing unit. As shown in table 4, for those with incomes $0–$5,000, the average 1988 tax increase per enrollee would be zero. For those with incomes of $20,000–$30,000, the average tax increase would be $160, with 68 percent of the tax returns in that income class affected. For incomes of $75,000–$200,000, the average tax increase would be $481, with 95 percent of the returns in that income class affected.

TABLE 4.—EFFECT OF THE SUBCOMMITTEE'S PROPOSAL TO TAX THE ACTUARIAL VALUE OF A PORTION OF MEDICARE BENEFITS

[Calendar year 1988]

Income class (1,000's of 1987 dollars)	Number returns [1] (1,000's)	Percent returns affected	Average change in tax per affected returns	Average change in tax per enrollee	Percent change in after-tax income [2]	Distribution of tax increase	
						(Billions)	(Percent)
$0 to 5	1,783.7	0.3	$111	$0	−0.0	$0.0	0.0
5 to 10	6,330.2	4.0	179	7	−.1	.0	1.0
10 to 15	4,271.5	29.5	234	62	−.5	.3	6.3
15 to 20	3,465.0	58.8	276	133	−.9	.6	12.0
20 to 30	4,701.2	68.1	317	160	−.9	1.1	21.7
30 to 50	3,776.6	91.0	457	282	−1.2	1.6	33.6
50 to 75	1,087.3	94.3	620	406	−1.1	.6	13.6
75 to 200	680.1	95.4	716	481	−.8	.5	9.9
200 and over	135.8	97.3	693	478	−.2	.1	2.0
Total	26,231.2	45.8	390	148	−.8	4.7	100.0

[1] Number of returns includes elderly and disabled tax units that do not file returns.
[2] After-tax income and inclusion amount does not reflect change in Medicare benefits under the bill.

Note: Estimates take into account deductibility of the inclusion amount as an itemized medical expense.

Source: Joint Committee on Taxation.

Table 5 shows the increased revenues for the Medicare program under the subcommittee's proposal, which assumes an effective date of taxable years ending after December 31, 1987, for including the actuarial value of a portion of Medicare benefits in adjusted gross income for taxation purposes.

TABLE 5.—ESTIMATED REVENUES FROM TAXING A PORTION OF THE VALUE OF MEDICARE BENEFITS AS INCLUDED IN THE SUBCOMMITTEE'S PROPOSAL

[In millions of dollars]

	Fiscal year—					Total fiscal year—	
	1988	1989	1990	1991	1992	1988–90	1988–92
Revenues	1,355	4,965	5,865	6,652	7,659	12,185	26,496

Source: Joint Committee on Taxation.

The subcommittee's proposal also provides that additional revenues would be raised by increasing the monthly part B premium in fiscal year 1988 by $1.30. Assuming current law, this additional amount would increase beginning in 1989 according to an earlier method of part B premium calculation under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged, or (2) the current premium amount increased by the most recent COLA adjustment. Table 6 shows the effect on the monthly part B (SMI) premium of this increase.

TABLE 6.—EFFECT ON MONTHLY PART B PREMIUM OF H.R. 1280/1281 AS APPROVED BY THE SUBCOMMITTEE ON HEALTH

	1987	1988	1989	1990	1991	1992
Premium, current law	$17.90	$22.00	$22.90	$23.90	$24.90	$26.00
Change, subcommittee proposal	0.00	1.30	1.40	1.40	1.50	1.50
New premium	17.90	23.30	24.30	25.30	26.40	27.50

Source: Congressional Budget Office.

The increase in revenues to the Medicare program from the part B premium increase would be as follows:

TABLE 7.—ESTIMATED REVENUES FROM INCREASING PART B PREMIUM IN 1988 AS INCLUDED IN THE SUBCOMMITTEE'S PROPOSAL

[In millions of dollars]

	Fiscal year—					Total, fiscal year—	
	1988	1989	1990	1991	1992	1988–90	1988–92
Revenues	375	525	555	590	630	1,455	2,675

Source: Congressional Budget Office.

The revenues raised by the subcommittee's proposal are sufficient to fund both the catastrophic benefits and the benefit improvements for home health, skilled nursing facility, and mental health benefits. As can be seen in table 8, the net budget effect of the proposal is −$670 million in fiscal year 1988, −$1.465 billion in fiscal year 1989, and −$565 million in fiscal year 1990, for a 3-year total of −$2.7 billion.

TABLE 8.—TOTAL REVENUES, OUTLAYS, AND NET BUDGET EFFECT OF SUBCOMMITTEE PROPOSAL

[In millions of dollars]

	Fiscal year—					Total, fiscal year—	
	1988	1989	1990	1991	1992	1988–90	1988–92
Revenues[1]	1,355	4,965	5,865	6,652	7,659	12,185	26,496
Catastrophic benefits[2]	700	3,240	4,940	5,990	7,075	8,880	21,945
Medicaid savings	−65	−305	−465	−560	−665	−835	−2,060
Medicaid buy-in to 100 percent	50	285	345	410	450	680	1,540
Benefit improvements[3]	0	280	480	595	725	760	2,080
Net budget effect	−670	−1,465	−565	−217	−74	−2,700	−2,991
Authorization	59	59	49	49	49	167	265

[1] Revenues include funds from tax on the actuarial value of the subsidized portion of Medicare benefits.
[2] Benefits are phased-in to be deficit neutral in all years, and a part of the costs are offset by a small part B premium beginning in calendar year 1988.
[3] Includes incremental improvements in home health, skilled nursing facility, and mental health benefits.

Source: Subcommittee on Health Staff.

SECTION V. H.R. 1245/S. 592, THE ADMINISTRATION BILL

A. Bill Description

This section provides a summary of H.R. 1245/S. 592, the Medicare Catastrophic Illness Coverage Act, the Administration bill.

REVISIONS IN HOSPITAL INSURANCE PROGRAM

1. Inpatient hospital services

a. Elimination of day limitation on inpatient hospital services.—The Medicare limits on payment for days of inpatient hospital care (90 days of inpatient hospital care during each spell of illness plus a lifetime reserve of 60 days) would be eliminated so that Medicare would pay for an unlimited number of hospital days for covered services. The 190-day lifetime limit on inpatient psychiatric hospital services would be retained.

b. Elimination of coinsurance amounts for inpatient hospital services.—The current hospital inpatient coinsurance amounts for days 61 through 90 and coinsurance for the 60 lifetime reserve days would be eliminated.

c. Inpatient hospital deductible.—The inpatient hospital deductible would apply no more than twice in a calendar year.

d. Elimination of spell of illness.—The "spell of illness" methodology would be eliminated for determining the number of hospital days Medicare would cover.

2. Post-hospital extended care (skilled nursing facility) services

a. Cover 100 days of care.—The Medicare program would cover 100 days of skilled nursing care services in a calendar year.

b. Eliminate coinsurance.—Skilled nursing facility coinsurance charges would be repealed.

c. Elimination of spell of illness.—The "spell of illness" methodology would be eliminated for determining the number of skilled nursing facility days.

CEILING ON BENEFICIARY EXPENSES

1. Eligibility for limit

Individuals would be required to enroll under part B in order to be protected by the catastrophic limit.

2. Limit

The annual ceiling on beneficiary covered expenses under parts A and B of Medicare would be $2,000 of the beneficiary's out-of-pocket covered expenses for Medicare parts A and B for 1988, and would be indexed in the future by the percentage change in total Medicare per capita expenses. Beneficiary out-of-pocket covered expenses incurred in the last quarter of the previous calendar year

could be substituted for expenses incurred in the last quarter of the current year in determining whether the ceiling on out-of-pocket expenses has been exceeded.

3. Expenses counted toward the limit

Beneficiary out-of-pocket expenses counted toward the ceiling would include the inpatient hospital deductibles, coinsurance under the hospice benefit, the part B deductible, the part B blood deductible, and coinsurance under part B. Amounts above the Medicare payments to physicians and others who did not accept assignment would not be included.

INCREASE IN SUPPLEMENTARY MEDICAL INSURANCE PREMIUM

1. Financing

The catastrophic coverage and the benefit changes would be financed by an increase in the currrent part B monthly premium sufficient to cover the costs of these changes.

2. Annual adjustments

The additional premium amount would be adjusted annually so that the premium covers the costs of the catastrophic coverage and benefit changes.

3. Trust fund transfers

Periodic transfers would be made from the part B trust fund to the part A trust fund of amounts which are attributable to expenses resulting from the part A benefit changes made by this bill.

EFFECTIVE DATE

The provisions would apply to items and services furnished after, and premiums for months after, 1987. Expenses incurred in the last quarter of 1987, however, could be substituted for expenses incurred in the last quarter of 1988 in counting toward the catastrophic limit.

B. IMPACT OF H.R. 1245/S. 592, THE ADMINISTRATION BILL

1. Effect on beneficiaries

H.R. 1245/S. 592 as proposed by the Administration places limits on a Medicare beneficiary's out-of-pocket costs for Medicare-covered services, as can be seen in the following table.

TABLE 1.—1989 MAXIMUM OUT-OF-POCKET BENEFICIARY PAYMENTS FOR MEDICARE-COVERED SERVICES UNDER H.R. 1245/S. 592, THE ADMINISTRATION BILL

Cost-sharing by benefit	Maximum beneficiary out-of-pocket payments for Medicare-covered services
Parts A and B catastrophic limit	[1] $2,150.00

[1] Potentially includes the 20 percent coinsurance for part B services, the part B deductible, the part B blood deductible, the two hospital inpatient deductibles (a maximum of $1,160), and any coinsurance under the hospice benefit. Does not include possible beneficiary out-of-pocket payments for (a) services Medicare does not cover (such as skilled nursing facility care after 100 days in a year or outpatient prescription drugs) or (b) charges in excess of Medicare's approved amounts on physician bills.

Source: Congressional Budget Office.

The average copayment (copayments are deductible and coinsurance amounts) to be paid by aged or disabled Medicare beneficiaries under H.R. 1245/S. 592 is estimated by the Congressional Budget Office to be $467 in 1989, compared to $542 under current law projections for 1989. The number of Medicare beneficiaries (aged and disabled) whose 1989 copayments would be reduced under the Administration bill is estimated by the Congressional Budget Office to be 1,633,000 (5.0 percent of beneficiaries); the average decrease in copayments would be $1,845. The number of beneficiaries whose 1989 copayments would rise is estimated to be 1,105,000 (3.4 percent); the average increase in copayments would be $542.

The number of Medicare beneficiaries (aged and disabled) who would be affected by the proposed limit on beneficiary cost-sharing under H.R. 1245/S. 592 is estimated by the Congressional Budget Office to be 1.65 million (5.2 percent of beneficiaries) in 1988, 1.75 million (5.4 percent) in 1989, 1.68 million (5.1 percent) in 1990, 1.68 million (5.0 percent) in 1991, and 1.65 million (4.8 percent) in 1992.

The Administration's proposal is financed by an increase in the monthly part B premium paid by enrollees. See the "Financing" section below for a description of this increase.

2. Financing

H.R. 1245/S. 592, the Administration's bill, would cost (excluding administrative costs but including the Medicaid offset) an additional $1.3 billion in fiscal year 1988, $2.2 billion in fiscal year 1989, and $2.5 billion in fiscal year 1990, for a three-year total of $6.0 billion. The outlay estimates for the proposal are shown in the following table.

TABLE 2.—OUTLAY EFFECT (NET OF ADMINISTRATIVE COSTS) OF H.R. 1245/S. 592, THE ADMINISTRATION BILL

[In millions of dollars]

	1988	1989	1990	1991	1992	Total 1988–90	Total 1988–92
Fiscal year outlays:							
Benefits	1,395	2,375	2,750	3,055	3,400	6,520	12,975
Medicaid offset	−115	−195	−225	−250	−280	−535	−1,065
Total	1,280	2,180	2,525	2,805	3,120	5,985	11,910

Source: Congressional Budget Office.

The Administration's bill, both the part A changes and the ceiling on out-of-pocket expenses, would be financed by increasing the part B premium currently paid by part B enrollees. The premium increase would be calculated to cover the actual cost of the catastrophic benefit. The Congressional Budget Office estimates the premium increase to be as follows:

TABLE 3.—EFFECT ON MONTHLY PART B PREMIUM OF H.R. 1245/S. 592, THE ADMINISTRATION BILL

	1987	1988	1989	1990	1991	1992
Current premium	$17.90	$22.00	$22.90	$23.90	$24.90	$26.00
Change, Administration bill	0.00	+6.10	+6.80	+7.30	+8.00	+8.70
New premium	17.90	28.10	29.70	31.20	32.90	34.70

SECTION VI. LEGISLATIVE COMPARISON OF CURRENT LAW, H.R. 1280/H.R. 1281 (AS APPROVED BY THE SUBCOMMITTEE ON HEALTH), AND H.R. 1245/S. 592 (ADMINISTRATION BILL)

The following table presents a comparison of current law and the subcommittee and Administration bills.

Current law	H.R. 1280/H.R. 1281 (as approved by the Subcommittee on Health)	H.R. 1245/S. 592 (Administration bill)
1. General approach: The Medicare program is not designed to include catastrophic coverage, i.e. coverage of long hospital or skilled nursing facility stays or coverage when the Medicare beneficiary's out-of-pocket costs exceed certain limits. Coverage under part A of Medicare (the Hospital Insurance program) includes inpatient hospital benefits for up to 90 days in a spell of illness, with an additional 60 days available over the beneficiary's lifetime. An inpatient hospital deductible ($520 in 1987) is required per spell of illness, and coinsurance must be paid by the beneficiary for days 61–90 in each spell of illness ($130 a day in 1987) and for the 60 lifetime reserve days ($260 a day in 1987). Special limits apply to inpatient services in a psychiatric hospital. Coverage of skilled nursing facility care is limited to up to 100 days per spell of illness, with coinsurance required after the first 20 days ($65 a day in 1987). Home health services have certain requirements for coverage. Hospice services are subject to durational limits and copayments for outpatient drugs and respite care. Coverage under part B of Medicare (the Supplementary Medical Insurance program) includes physicians' services and other medical services, for which the beneficiary is required to pay a yearly deductible ($75 in 1987) and 20% coinsurance. Special limits apply to outpatient psychiatric physician's services.	Provides Medicare catastrophic coverage for those persons voluntarily enrolling in part B by limiting beneficiary cost-sharing amounts for certain Medicare-covered services. Provides for all Medicare beneficiaries unlimited inpatient hospital days, repeals inpatient hospital coinsurance, requires only one inpatient hospital deductible per year, provides up to 150 days of skilled nursing facility (SNF) care per year, requires SNF coinsurance charges for the first 7 days only, revises the calculations of SNF coinsurance charges, eliminates the SNF 3-day hospitalization requirement, and expands benefits for hospice, home health, and outpatient mental health. Finances the catastrophic coverage and benefit changes by including a portion of the actuarial value of Medicare benefits as taxable income for Medicare beneficiaries and increasing the part B premium in 1988.	Provides Medicare catastrophic coverage for those persons voluntarily enrolling in part B by limiting beneficiary cost-sharing amounts for certain Medicare-covered services. Provides for all Medicare beneficiaries unlimited inpatient hospital days, repeals inpatient hospital coinsurance, requires no more than two inpatient hospital deductibles per year, provides up to 100 days of skilled nursing facility (SNF) care per year, and eliminates SNF coinsurance charges. Finances the catastrophic coverage and benefit changes by an increase in the monthly part B premium, which would be adjusted annually to cover the cost of the catastrophic coverage and benefit changes.

In addition to out-of-pocket payments resulting from Medicare's benefit limits and cost-sharing requirements (e.g., deductibles and coinsurance), Medicare beneficiaries may also be required to pay the difference between their physician's charges (and charges for some other part B services) and the amount Medicare will reimburse. Hospitals, however, may not charge Medicare beneficiaries for their costs which are in excess of what the Medicare program will pay for covered inpatient hospital services. The Medicare (part A) Hospital Insurance Trust Fund is financed primarily through Social Security payroll tax contributions paid by employers, employees and the self-employed. The Medicare (Part B) Supplementary Medical Insurance Trust Fund is financed through a combination of enrollee premiums ($17.90 a month in 1987) and general revenues.		
2. Hospital benefit:		
a. Number of days—Beneficiaries are entitled to inpatient hospital services for up to 90 days in any one "spell of illness." In addition, each beneficiary has a lifetime reserve of 60 days after the 90 days has been exhausted.	Provides for unlimited inpatient hospital days.	Provides for unlimited inpatient hospital days.

Current law	H.R. 1280/H.R. 1281 (as approved by the Subcommittee on Health)	H.R. 1245/S. 592 (Administration bill)
b. Coinsurance—Beneficiaries are required to pay coinsurance when inpatient hospital services are received for more than 60 days during a "spell of illness." The beneficiary is responsible for a coinsurance amount for each day after the 60th and through the 90th day equal to one-fourth of the inpatient hospital deductible ($130 a day in 1987). There is also a coinsurance amount for each day that is chargeable against the individual's 60 lifetime reserve days, equal to one-half of the inpatient hospital deductible ($260 a day in 1987). After a beneficiary has received 90 days of care in a spell of illness and exhausted the 60-day lifetime reserve days, Medicare does not provide for further hospital reimbursement, and the beneficiary is responsible for all hospital charges.	Repeals inpatient hospital coinsurance charges, including those required for emergency hospital services provided by a hospital that does not participate in Medicare.	Repeals inpatient hospital coinsurance charges.
c. Deductible—Beneficiaries are requried to pay a first day hospital deductible for inpatient hospital services furnished in each "spell of illness" ($520 in 1987). The amount of the hospital deductible by law is revised each January and is equal to the inpatient hospital deductible for the preceding calendar year, updated by the same percentage that applies to prospective payment system (PPS) rates and adjusted to reflect changes in real case mix.	Requires only one inpatient hospital deductible for the first period of continuous hospitalization that begins in a calendar year. Beneficiaries whose spell of illness begins before Jan. 1, 1988, and ends after that date would not be required to pay an additional deductible during that spell of illness during 1988 or 1989. Provides that the deductible would be $520 for 1987, increased in subsequent years by the cost-of-living adjustment for Social Security benefits.	Requires no more than two inpatient hospital deductibles per year, and these could be counted toward the catastrophic limit.

d. Spell of illness—A "spell of illness" is a period of consecutive days that begins with the first day on which a patient is furnished inpatient hospital or extended care services and ends with a period of 60 consecutive days during which the beneficiary was neither an inpatient of a hospital nor a skilled nursing facility. A beneficiary may be discharged from and readmitted to a hospital or skilled nursing facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission.	Repeals the spell of illness concept.	Repeals the spell of illness concept.
e. Adjust PPS rates—Hospitals in general are paid on the basis of a prospective payment system in which Medicare pays a prospective amount for each Medicare discharge based on one of the 476 different diagnosis-related groups (DRGs). The DRG payments are based on the assumption that Medicare will cover at most 90 days of covered hospital services in a "spell of illness" and 60 lifetime reserve days.	When adjusting the payment rates under the prospective payment system (PPS), the outlier cutoff points, the weighting factors, and the target amounts for paying non-PPS hospitals, requires the Secretary, when appropriate, to take into account reductions in beneficiary payments to hospitals resulting from the repeal of the day limit on inpatient hospital services.	No provision.
3. Skilled nursing facility (SNF) benefit:		
a. Number of days—A beneficiary is entitled to post-hospital extended care services in a qualified skilled nursing facility for up to 100 days in any one "spell of illness."	Provides for up to 150 days of SNF care per year.	Provides for up to 100 days of SNF care per year.
b. Coinsurance—The beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day after the 20th and before the 101st day of SNF services furnished during a "spell of illness" ($65 a day in 1987).	Requires beneficiaries to pay coinsurance amounts for the first 7 days only. Provides that coinsurance amounts would equal 20% of the estimated national average per diem Medicare reasonable cost for SNF services in the succeeding calendar year.	Repeals SNF coinsurance charges.

Current law	H.R. 1280/H.R. 1281 (as approved by the Subcommittee on Health)	H.R. 1245/S. 592 (Administration bill)
c. Spell of illness—A "spell of illness" is a period of consecutive days that begins with the first day on which a patient is furnished inpatient hospital or extended care services and ends with a period of 60 consecutive days during which the beneficiary was neither an inpatient of a hospital nor a skilled nursing facility. A beneficiary may be discharged from and readmitted to a hospital or skilled nursing facility several times during a spell of illiness and still be in the same spell if 60 days have not elapsed between discharge and readmission.	Repeals the spell of illness concept.	Repeals the spell of illness concept.
d. Prior hospitalization requirement—SNF services are covered under Medicare only after an individual has been transferred to the facility from a hospital in which the individual was a patient for not less than three consecutive calendar days before being discharged in connection with the transfer.	Repeals the three-day prior hospitalization requirement.	No provision.

4. Hospice: A beneficiary who is certified by the beneficiary's attending physician as terminally ill is entitled to elect to receive hospice care for two periods of 90 days and one subsequent period of 30 days for a total of 210-days of hospice care. Certain hospice benefits—outpatient drugs and respite care—are subject to copayments by the beneficiary. In the case of drugs, the copayment is an amount (not to exceed $5 per prescription) equal to 5% of the cost of the drug to the hospice program. For respite care, the copayment is equal to approximately 5% of the estimated payments to the hospice program for respite services, but not to exceed the applicable Medicare hospital deductible during the period of a hospice election (as long as the hospice election is not broken by more than 14 days).	Provides for a subsequent extension period beyond the current 210-day limit if the beneficiary is still certified as terminally ill by the attending physician or hospice director.	Counts hospice coinsurance charges toward the catastrophic limit.
5. Blood deductible: A beneficiary is required to pay a separate deductible equal to the cost of the first three pints of whole blood (or equivalent quantities of red blood cells) received by a beneficiary as part of the services furnished under the hospital insurance (part A) program during each "spell of illness." There is also a separate deductible under part B of Medicare equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of red blood cells) furnished to a beneficiary during a calendar year.	Provides that beneficiaries would be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year rather than each spell of illness. Requires beneficiaries to pay only one blood deductible under parts A or B in any calendar year. Provides that the blood deductible could be reduced by replacing the blood. Provides that the part B blood deductible would not be required after the catastrophic limit is reached.	No provision.

Current law	H.R. 1280/H.R. 1281 (as approved by the Subcommittee on Health)	H.R. 1245/S. 592 (Administration bill)
6. Home Health: Home health services are covered under Medicare if the beneficiary is homebound, needs intermittent skilled nursing care or physical or speech therapy, and the services are ordered by, and included in the plan of treatment established by, the physician. To meet the requirement for intermittent skilled nursing care, the individual must have a medically predictable recurring need for skilled nursing services. Current guidelines define "intermittent" as permitting daily skilled nursing visits for up to 8 hours a day, for up to two to three weeks, or longer under unusual circumstances, if medically reasonable and necessary. "Daily" is defined in guidelines as 5 days per week. While guidelines have provided these definitions of "intermittent" and "daily" skilled nursing visits, there have been problems in consistent interpretation of these guidelines.	Defines "intermittent" nursing care and home health aide services to mean (1) those provided or needed less than 7 days each week and (2) where provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days and for a subsequent period based on physician certification of exceptional circumstances.	No provision.
7. Outpatient Mental Health: The maximum Medicare reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for outpatient treatment of mental, psychoneurotic, or personal disorder is $250 per calendar year for each Medicare beneficiary. Medicare recognizes a maximum of 62.5% of $500 of charges, or $312.50, and will reimburse 80 percent of this amount, or $250. Consequently, the effective coinsurance rate is 50% for the first $500.	Raises the current law maximum Medicare reimbursement for mental health outpatient services from the current limit of $250 to $1,000 per calendar year. The coinsurance requirement would remain the same.	No provision.
8. Catastrophic limit: a. Eligibility for the limit on out-of-pocket expenses—Medicare currently provides no limit on beneficiary cost-sharing amounts.	Requires that Medicare beneficiaries be enrolled in part B to be eligible for the limit.	Requires that Medicare beneficiaries be enrolled in part B to be eligible for the limit. The inpatient hospital charges could not be counted toward the limit unless the beneficiary is covered under part A.

b. Limit—	$1,043 for 1988, indexed in future years to increases in the Social Security cost-of-living adjustment.	$2,000 for 1988, indexed in future years to percentage changes in total Medicare per capita expenses.
c. Expenses counted toward limit—	Beneficiary out-of-pocket expenses for part B services (the part B deductible, the part B blood deductible, and the 20% part B coinsurance).	Beneficiary out-of-pocket expenses for the inpatient hospital deductibles, coinsurance under the hospice benefit, and for part B services (the part B deductible, the part B blood deductible, and the 20% part B coinsurance). Expenses occurring in the last quarter of the previous year may be substituted for those in the last quarter of the current year, if greater.
d. Medicare payment after limit is reached—	100% of the reasonable charges (in some cases, the reasonable costs) for covered part B services when the catastrophic limit is exceeded for that year, and the beneficiary would not be required to pay the part B blood deductible.	100% of beneficiary cost-sharing amounts for the inpatient hospital deductibles, hospice care coinsurance, the part B deductible, and covered part B services when the catastrophic limit is exceeded for that year.
9. Financing:		
The Medicare part A Hospital Insurance Trust Fund is financed primarily through Social Security payroll tax contributions paid by employers, employees and the self-employed. The payroll tax rate for calendar year 1987 is 1.45 percent of earnings up to $43,800 per employee. An equal contribution rate is paid by the employer.	Finances the catastrophic coverage by including the following in taxable gross income: for beneficiaries entitled to Medicare part A, 50% of the Medicare part A per capita actuarial value; for beneficiaries entitled to Medicare part B, 75% of the part B per capita actuarial value.	Finances the catastrophic coverage and the benefit changes by an increase in the current part B monthly premium sufficient to cover the costs of these changes. The additional premium amount would be adjusted annually so that the premium covers the costs of the catastrophic coverage and benefit changes.
The Medicare part B Supplementary Medical Insurance Trust Fund is financed through a combination of enrollee premiums and Federal general revenues. The Secretary is required to calculate the premium amount so as to produce premium income equal to 25% of program costs for enrollees age 65 and over. The annual increase in the part B premium cannot exceed the rate of increase in the cost-of-living (COLA) adjustment for the Social Security program. Beginning in 1989, the premium calculation will revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged, or (2) the current premium amount increased by the most recent COLA adjustment.	Provides that the inclusion would not apply to individuals who must pay a premium in order to receive part A coverage or to qualified nonresidents. A qualified nonresident is an individual (1) who has been outside of the United States for at least 330 full days during the current and 4 preceding calendar years, (2) who has received no medical services during the current and 4 preceding calendar years, for which payment will be made under Medicare part A, and (3) who is not entitled to Medicare part B benefits at any time during the current and 4 preceding calendar years. Provides that the United States includes possessions thereof.	Provides for periodic transfers from the part B Trust Fund to the part A Trust Fund of amounts which are attributable to expenses resulting from the part A benefit changes made by this bill.
	Provides that tax liabilities received from beneficiaries entitled to part A would be transferred from the general fund of the Treasury to the Federal Hospital Insurance Trust Fund.	

Current law	H.R. 1280/H.R. 1281 (as approved by the Subcommittee on Health)	H.R. 1245/S. 592 (Administration bill)
The insurance value of Medicare benefits is not included in the gross income of the beneficiary. The Internal Revenue code permits a deduction for uninsured expenses and insurance premiums paid during the taxable year for medical care of the taxpayer, his spouse, or a dependent to the extent that such expenses exceed 7.5 percent of adjusted gross income. Premiums paid for Medicare parts A and B coverage are allowable medical expenses. Neither the hospital insurance (part A) payroll tax nor the value of Medicare benefits is a deductible medical expense.	Requires that the Secretary of Health and Human Services mail an information return stating the aggregate amount of the included portion of Medicare parts A and B coverage with respect to any individual. Provides that the value of Medicare coverage included in gross income would be allowable as an itemized deduction for tax purposes to the extent that the taxpayer's total medical expenses (including medical expenses attributable to this provision) exceed 7.5% of adjusted gross income. Raises additional revenues by increasing the monthly part B premium by $1.30 per month in 1988 to assure budget neutrality.	
10. Determination of part A premium: Individuals age 65 or over who are not entitled to Hospital Insurance (part A) benefits may voluntarily enroll in the Hospital Insurance program if they pay a monthly premium. The Secretary is required to calculate the premium each year under a formula that is equal to $33 multiplied by the ratio of the inpatient hospital deductible for the subsequent calendar year to the deductible promulgated for 1973.	Requires the Secretary to establish a part A premium for those who voluntarily enroll in part A equal to the actuarial value of the part A benefit. The actuarial value would equal one-twelfth of the estimated average per capita amount payable from the Hospital Insurance Trust Fund for services and related administrative costs incurred in the succeeding calendar year for individuals age 65 and over entitled to hospital benefits during that entire year.	No provision.
11. Requirements for Medicare supplemental health insurance policies: Medicare supplemental health insurance policies ("medigap" policies) must meet minimum standards before companies can market them as medigap policies. The standards are contained in a model regulation approved by the National Association of Insurance Commissioners (NAIC) on June 1, 1979, and incorporated in section 1882 of the Social Security Act.	Requires the Secretary to recommend to Congress, within 150 days after enactment of the legislation, Model Standards for Medicare supplemental policies, taking into consideration the amendments provided in this bill and any recommendations developed by the National Association of Insurance Commissioners.	No provision.

The standards contained in section 1882 require medigap policies to: (1) cover all of the Medicare part A inpatient coinsurance for the 61st through 90th day in the hospital, and the 91st through 150th day lifetime reserve days, plus 90 percent of covered hospital inpatient expenses for a lifetime maximum of up to 365 days after the insured has exhausted Medicare benefits, (2) cover the Medicare part B coinsurance, which may be subject to a $200 deductible and a maximum benefit of $5,000 per year, (3) cover the part A and B blood deductibles, (4) not define preexisting conditions more restrictively than as a condition that was diagnosed or treated within 6 months before the effective date of the policy, (5) automatically change as Medicare's deductibles and coinsurance requirements change, (6) have a "free look" period, during which an individual may return an unwanted policy for cancellation and receive a full refund of any premium paid, (7) provide cancellation and termination clauses to be prominently displayed, and (8) at the time of sale, provide a buyers guide explaining benefits and limitations of Medicare and Medicare supplemental insurance.

Medicare supplemental policies would be required, on a one-time basis, to send a letter to their policyholders who are entitled to Medicare by Jan. 31, 1988, explaining the improved benefits contained in the catastrophic legislation passed by the Congress and how these improvements will affect the benefits contained in the policies and the cost of the premium.

Medicare supplemental policies would be required to submit their advertising files to the State Insurance Commission for review as to whether their marketing practices comply with State law.

Current law	H.R. 1280/H.R. 1281 (as approved by the Subcommittee on Health)	H.R. 1245/S. 592 (Administration bill)
In addition, section 1882 establishes loss ratio targets for medigap policies that set a goal for the percentage of insurance premiums to be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies.	Federal penalties for noncompliance with the substantial duplication of health benefits requirement contained in section 1882(d)(3)(A) would be suspended from Jan. 1, 1988, to Dec. 31, 1989, for two years for existing Medicare supplemental policies, but new policies would still be subject to the penalties and fines of not more than $25,000 or imprisonment for not more than five years, or both, after Medicare catastrophic legislation is enacted.	
	Within two years of the passage of this legislation, States would be required to amend their State laws regulating Medicare supplemental policies in accordance with the above Federal changes in section 1882 of the Social Security Act.	
The law contains Federal sanctions, consisting of fines and/or imprisonment, for (1) furnishing false information to obtain the Secretary's certification, (2) posing as a Federal agent to sell medigap policies, (3) knowingly selling policies that duplicate coverage the individual already has, and (4) selling supplemental policies by mail in States that have not approved, or are deemed not to have approved, their sale.		

12. Medicaid buy-in for poor and elderly and disabled: Some aged and disabled Medicare enrollees are also covered by State Medicaid programs. All State Medicaid plans, except for the Wyoming plan, pay the monthly Medicare part B premium payment for these dual eligible beneficiaries under a "buy-in" agreement. Eligibility for Medicaid is linked to actual or potential receipt of cash assistance. For the aged and disabled, such assistance is obtained through the Federal Supplemental Security Income (SSI) program. While States may "buy-in" to part B of Medicare for both their cash assistance and non-cash assistance populations who are eligible for Medicare, Federal matching for premium payments is available only for the cash assistance group. If a State does not buy-in for part B coverage, it cannot receive Federal matching payments for medical services which would have been covered under Medicare if there had been a buy-in arrangement. Some States also pay some or all of the Medicare coinsurance (generally 20 percent of the "reasonable charge") and deductible amounts.	Amends the Federal Supplemental Security Income (SSI) program to establish a separate category of elderly and disabled for whom State Medicaid programs, including States operating under 1115 waivers, would be required to pay the Medicare premium, deductibles, and coinsurance amounts. All elderly and disabled with incomes up to the Federal poverty level (incomes up to $5,200 for an elderly individual) would be entitled to participate in this program. This proposal would not require the States to make payment for regular Medicaid benefits. States would be required to use the SSI resource standards, or a higher resource standard, in determining eligibility.	No provision.
13. Beneficiary notice requirement: No provision.	Requires the Secretary to prepare an annual notice to be included with Social Security checks which must provide a simple, clear explanation of Medicare benefits. This notice must also include an explanation of the limits of the Medicare and Medicaid programs with regard to long-term care benefits. In addition, a directory of participating physicians would be sent to each beneficiary each year starting in January 1988.	No provision.
14. Health Maintenance Organization payment provisions: Health Maintenance Organizations may participate in Medicare if they provide a minimum scope of services as well as meet certain other requirements related to their organizational structure and financial operations.	Requires the Secretary to provide for an appropriate adjustment in payment amounts to HMOs.	No provision.

Current law	H.R. 1280/H.R. 1281 (as approved by the Subcommittee on Health)	H.R. 1245/S. 592 (Administration bill)
15. Effective date Not applicable.	Generally applies in 1988. The limitation on out-of-pocket expenses, elimination of the SNF 3-day prior hospitalization requirement, and the home health and outpatient mental health changes are effective January 1, 1988. The Medicaid buy-in would be effective beginning in July 1988.	Applies to items and services furnished after, and premiums for months after, 1987 (except expenses incurred in the last quarter of 1987 may count toward the catastrophic limit).

SECTION VII. COMPARISON OF THE IMPACT OF H.R. 1280/ H.R. 1281 (AS APPROVED BY THE SUBCOMMITTEE ON HEALTH) AND H.R. 1245/S. 592 (THE ADMINISTRATION BILL)

The general scope of both the Subcommittee on Health's proposal (H.R. 1280/H.R. 1281) and the Administration's bill (H.R. 1245/S. 592) is similar. Catastrophic coverage would be provided by expanding certain existing benefits (e.g., providing unlimited inpatient days and eliminating inpatient hospital coinsurance) and by establishing a limit on out-of-pocket payments for Medicare beneficiaries enrolled in part B. The benefits in the proposals differ in several ways. The Subcommittee's proposal requires only one inpatient hospital deductible per year, while the Administration's bill provides for a maximum of two deductibles.

The Subcommittee proposal provides up to 150 days of skilled nursing facility (SNF) care, with copayments (under a revised calculation) on the first seven days per year, while the Administration's bill provides up to 100 days of SNF care with no coinsurance. The Subcommittee's proposal has a cap on out-of-pocket part B expenses of $1,043 in 1989, indexed in future years to increases in the Social Security cost-of-living adjustment. The Administration's bill has a higher cap, $2,150 in 1989, which in addition to part B out-of-pocket expenses, can include the inpatient hospital deductibles and hospital care coinsurance, and is indexed in future years to changes in total Medicare per capita expenses. The Subcommittee's proposal also expands benefits for SNF care (by eliminating the three-day prior hospitalization requirement), and for hospice, home health, and outpatient mental health services.

The Subcommittee on Health's proposal, with its lower limit on out-of-pocket expenses and larger benefit expansions in other areas, is estimated by the Congressional Budget Office to increase the average Medicare benefit per enrollee from the current $3,210 to $3,358 in 1989, while the Administration's proposal would increase the average benefit to $3,290 (see table 1).

The 1989 Medicare cost per enrollee of the Subcommittee's proposal would be higher, $168 compared to $81 per enrollee under the Administration's bill. However, the average copayment that Medicare beneficiaries would pay out-of-pocket, currently $542, would be lower under the Subcommittee's proposal ($402) than under the Administration's bill ($467).

Table 1 also shows that the number of enrollees whose copayments would be reduced is almost five times larger under the Subcommittee's proposal than under the Administration's bill. However, the average decrease in copayments would be larger under the Administration's bill, −$1,845 compared to −$602 under the Subcommittee proposal. The number of enrollees whose copayments would rise under the Subcommittee's proposal is about one-third

the number under the Administration's bill, with the average increase in copayments being $406, compared to $542 under the Administrations' bill.

TABLE 1.—COMPARISON OF 1989 IMPACT OF H.R. 1280/H.R. 1281, THE SUBCOMMITTEE'S PROPOSAL, AND H.R. 1245/S. 592, THE ADMINISTRATION BILL

	Current law	Subcommittee proposal	Administration bill
Average benefit per enrollee	$3,210	$3,358	$3,290
Medicare cost per enrollee for proposed new benefits		$168	$81
Average enrollee copayment	$542	$402	$467
Enrollees for whom copayments fall:			
Number		7,778,000	1,633,000
Percent of total enrollees		24.0	5.0
Average decrease in copayment		−$602	−$1,845
Enrollees for whom copayments rise:			
Number		337,000	1,105,000
Percent of total enrollees		1.0	3.4
Average decrease in copayment		+$406	+$542

Source: Congressional Budget Office.

Since the Subcommittee's proposal has a lower cap on out-of-pocket expenses paid by beneficiaries ($1,043 in 1989 compared to $2,150 in the Administration's bill), the number of beneficiaries who reach the cap is greater than under the Administration proposal, as can be seen in table 2. The percentage of beneficiaries reaching the cap increases over time under the Subcommittee's proposal, while it falls after 1989 under the Administration bill.

TABLE 2.—COMPARISON OF NUMBER AND PERCENT OF MEDICARE ENROLLEES AFFECTED BY THE CAPS IN THE SUBCOMMITTEE'S PROPOSAL AND THE ADMINISTRATION'S BILL, 1988–92

	1988	1989	1990	1991	1992
Subcommittee proposal					
Enrollees affected by the cap:					
Number	(1)	2,720,000	3,000,000	3,270,000	3,530,000
Percent of all enrollees	(1)	8.4	9.1	9.7	10.3
Administration bill					
Enrollees affected by the cap:					
Number	1,650,000	1,750,000	1,680,000	1,680,000	1,650,000
Percent of all enrollees	5.2	5.4	5.1	5.0	4.8

[1] Cap would be effective in 1989.

Source: Congressional Budget Office.

The annual cost to the Medicare program (net of administrative costs and the Medicaid effect) of the Subcommittee's proposal is larger than under the Administration bill because of the greater benefits, as can be seen in table 3.

TABLE 3.—COMPARISON OF OUTLAY ESTIMATES OF SUBCOMMITTEE PROPOSAL AND ADMINISTRATION BILL, FISCAL YEARS 1988–92

[In millions of dollars]

	Fiscal year—					Total, fiscal year—	
	1988	1989	1990	1991	1992	1988–90	1988–92
Subcommittee proposal	[1] 700	3,520	5,420	6,585	7,800	9,640	24,025
Administration bill	1,395	2,375	2,750	3,055	3,400	6,520	12,975

[1] Certain new benefits would not be effective until 1989.

Source: Congressional Budget Office.

A primary difference between the Subcommittee's proposal and the Administration's bill is the method of financing the catastrophic coverage. The Subcommittee's proposal would include in the gross income of Medicare beneficiaries, subject to taxation, a portion of the actuarial value of Medicare benefits. The average increase in a Medicare beneficiary's tax would be $148. However, the amount could range from $0 to $481, depending on the beneficiary's income.

Not all Medicare beneficiaries would be affected by the inclusion. The Joint Committee on Taxation has estimated that approximately 46 percent of the 1988 tax returns of the elderly and disabled would be affected, primarily those filing units with incomes over $20,000. Of the returns affected by the inclusion, only about 13 percent would be from the elderly and disabled with incomes below $15,000. The average change in the tax per enrollee with income below $15,000 ranges from $0 for those with incomes up to $5,000 to $62 for those with incomes from $10,000 to $15,000.

Under the Subcommittee's proposal, all Medicare beneficiaries enrolled in part B would also pay an increase in the part B premium of $1.30 per month in 1988, or $15.60 a year.

Under the Administration's proposal, the catastrophic program would be financed by an increase in the part B premium to be paid by all Medicare beneficiaries who voluntarily enroll in part B. The increase in the premium in 1988, estimated by the Congressional Budget Office to be $6.10 per month (or $73 a year), would be paid by all part B enrollees, regardless of their income.

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